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MEDICARE AND MEDICAID BUDGET RECONCILIATION

HEARINGS

BEFORE THE

SUBCOMMITTEE ON
HEALTH AND THE ENVIRONMENT

OF THE

COMMITTEE ON
ENERGY AND COMMERCE
HOUSE OF REPRESENTATIVES

ONE HUNDRED THIRD CONGRESS

FIRST SESSION

MARCH 31 AND APRIL 1, 1993

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MEDICARE BUDGET RECONCILIATION

WEDNESDAY, MARCH 31, 1993

House of Representatives,
Committee on Energy and Commerce,
Subcommittee on Health and the Environment,
Washington, DC.

The subcommittee met, pursuant to notice, at 9:45 a.m., in room 2226, Rayburn House Office Building, Hon. Henry A. Waxman (chairman) presiding.

Mr. Waxman. The meeting of the subcommittee will come to order.

Today's hearing will focus on the President's Medicare proposals to meet the deficit reduction targets included in the recently adopted House passed budget. The resolution calls for a 5 year cut in Medicare outlays, of $48.3 billion.

We are also holding a hearing tomorrow on the administration's budget proposals relating to Medicaid, where savings of $7.8 billion over 5 years have been assumed in the budget resolution. This dwarfs the $2.9 billion in Medicaid cuts enacted in 1990. It is also the largest cut in Federal Medicaid spending since 1981.

This coming fiscal year 35.6 million lower income Americans will be covered by Medicaid. This means that for the first time Medicaid beneficiaries will equal the number of Americans covered by Medicare. About one-half of those will be poor children, and roughly another quarter will be poor women. The remaining beneficiaries will be elderly or disabled.

I have asked our first witness today, Mr. William Toby, Acting Administrator of the Health Care Financing Administration, to present the administration's recommendations on both Medicare and Medicaid outlay reductions in order to accommodate his schedule.

Before calling on Mr. Toby, I want to make it clear that I support the President's goal of strengthening our economy and reducing the Federal deficit. I also want to applaud the President's commitment to health care reform, as an essential component of economic recovery. There is no question that we cannot sustain our economic growth, improve productivity, and become more competitive, unless we invest in the health of all Americans and control health costs.

Toward that end, I believe we need to examine the President's Medicare and Medicaid proposals in light of our health reform goals. I have previously expressed my view that, to the extent possible, we should apply savings from publicly financed health programs to an expansion of health coverage. While the savings in the President's budget are aimed at reducing the deficit, I expect that we will have a chance to improve the Medicare program when we take up health care reform legislation later this year.

I am concerned that the magnitude of the proposed reductions in Medicare payments could, if not accompanied by effective cost controls, significantly increase the cost of health services in the private sector. This has been the result of past deficit reduction policies that were not linked to comprehensive reform.

I also want to underscore the need for caution in making further reductions in Medicare payment amounts, in light of the substantial cuts made as a result of the 1990 Budget agreement. OBRA 90 includes some $44 billion in Medicare cuts that are still being implemented.

While there is little evidence to date of a decline in the access or quality of services available to beneficiaries, we must take care not to erode the broad support which the Medicare program has enjoyed from both beneficiaries and providers.

The administration has recommended a series of policy changes in part B of Medicare that would save, according to the Congressional Budget Office, about $25.9 billion over 5 years. The proposals fall into three categories: first, reductions in outpatient service and equipment payments; second, revisions to the Medicare fee schedule for physician services; and third, adjustments to the formula for setting part B premiums.

In addition, the budget also recommends modifications to the Medicare secondary payer policy and to payments for home health services, and direct medical education that are within this committee's jurisdiction.

We are expecting additional detail on these proposals when the administration's fiscal year 1994 budget is sent to Congress next week. However, I believe today's hearing can help the subcommittee understand the administration's rationale for these policy changes and what impact they will have on beneficiaries, providers and practitioners.

I cannot stress enough, the importance of carefully considering the interaction of changes in Medicare on private payers and on those institutions and practitioners that serve the program's beneficiaries. We certainly don't want to make our current problems worse. We must make responsible choices that can advance our reform goals of universal coverage and across the board cost containment.

I know our witnesses will give us practical and constructive advice, about how we can best meet these challenges.

I want to recognize members of the subcommittee for opening comments that they may wish to make before we hear from our witnesses. Mr. McMillan, we are pleased to have you here today. I want to call on you now for any opening comments.

Mr. McMillan. I thank the chairman, and I won't take long. We have one heck of a problem. We have had it for probably a decade, and refused to recognize it. That's the fact that health care costs are running out of control, and they impact the Federal budget enormously.

Medicare and Medicaid are projected to grow, unless we do something, at a rate in excess of 12 percent a year for the foreseeable future. Close to 60 percent of the increase in spending in the Federal budget this year derives from those two programs alone.

We can point a lot of the blame and waste a lot of time doing so. I don't think it's necessary to point blame. What is necessary, is for the medical care community and the Congress to face the issue candidly and begin to make some decisions. As much as we would like to have all the health care that could be created and generated, the fact of the matter is that we have to do with what we can pay for. That applies to the Federal Government, it applies to hospitals, it applies to doctors, it applies to trial lawyers, it applies to patients. We are all going to have to participate in finding the solutions.

We do have the beginnings of it in the President's proposal, some of the things that we will consider here today. The Republicans presented alternatives in the Budget Committee. The President asked us to come up with specific suggestions, and we did. They are not adequate either in total. But nevertheless, they are a beginning.

To suggest that through budgetary action that the Congress or the Government shouldn't set some guidelines, in my judgment, is ridiculous. A budgeting is a process of setting goals. Sometimes it's tough medicine. But the fact of the matter is that many providers out there have not been exercising cost control, nor have the consumers of medical care been exercising cost control, in many cases because they don't participate in the decisions that relate to their health care with respect to the cost of it.

All of us are going to have to participate in finding those solutions. There are a whole array of potential areas for cost reduction that I think we need to consider. It may well be that the Government has to force that to some degree, in what is included in health care reform. I think that basically the health care community, instead of screaming about how that affects their respective turfs, should join in the crusade to find the solution to this problem.

I beg of you, to take a constructive approach to this. There is no way that we are going to address the problem of health care cost or solve the problems of lack of access unless everybody puts their shoulders to the wheel and participates financially and otherwise in finding a solution. I hope that we can discover some of those as we proceed here today.

Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you, Mr. McMillan. Dr. Rowland.

Mr. ROWLAND. Thank you, Mr. Chairman. Thank you for this hearing today, so that we will have an opportunity to hear first hand the concerns of the witnesses testifying on the impact of the Medicare provisions in the President's proposed budget for fiscal year 1994.

I am sure that all of us would agree with President Clinton, that we need to get our Nation's economy back on the road to recovery, and we are willing to share in the sacrifices to meet this goal. However, as we make these budget decisions it will be important for us to make sure that the patients, providers and others in the health care system are treated fairly.

At a time when we are preparing to move forward with health care reform we must make sure that these cuts do not further erode our Nation's health care system.

Thank you again, Mr. Chairman. I look forward to hearing the witnesses today.

Mr. WAXMAN. Thank you, Dr. Rowland. Mr. Wyden.

Mr. WYDEN. Thank you, Mr. Chairman. I will be brief. I want to congratulate you, Mr. Chairman, for digging into these issues so promptly as you always have.

I am particularly concerned today about the impact of the Medicaid proposal as it relates to this very large cut in personal care services for the low income individuals. What concerns me is that this is one of the programs that allows us to have a genuine alternative to institutional care for those who are vulnerable and poor and aged, and I am very interested in working with the administration to see if we can make those dollars stretch to serve the needy through personal care services, given the fact that we still don't have a long term care policy for our country.

I think it's also worth noting that the cuts to personal care services are a very large portion of the overall Medicaid cuts. It seems to me that we ought to be working to try to figure out new cost containment tools to address the matter of savings rather than to make cuts in the personal care services of this magnitude that, in my view, would step us backwards in terms of trying to address the needs of those who are disabled. Also, not address the need for our country to come up with a sensible long term care policy as the President so wisely called for.

Mr. Chairman, I thank you, and look forward to our witnesses from HCFA and from other organizations.

Mr. WAXMAN. Thank you, Mr. Wyden. Mr. Kreidler.

Mr. KREIDLER. Thank you, Mr. Chairman. I, too, will be brief. I will be looking forward to learning more about the administration's Medicare proposals in working with you to meet our budget goals without reducing the quality of service to beneficiaries.

I think this can be done, and it certainly must be done. I am concerned that we are being asked to go through yet another year of fine tuning, making very subtle technical adjustments, to a very complex and very inefficient fee for service system that drives Medicare physician payments.

I know that this committee has done a great deal to make that system work better for patients and for taxpayers in the past few years, but I have to wonder whether we will ever be done with fine tuning as long as we stick with fee for service reimbursement.

That's why I am looking forward to the President's health care plan, which I hope will move Medicare and the rest of our system toward capitation payments, where providers have to be accountable for the costs of care as well as quality. I am especially impressed at the interest the hospitals have shown in this concept.

I am looking forward to hearing from the witnesses. I know some of them will disagree strongly with some of the proposals, and I understand why. But I hope that they will offer us some real concrete, workable alternatives to achieve the savings we must achieve this year and in the long term.

Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you, Mr. Kreidler. Mr. Greenwood, do you have an opening statement?

Mr. GREENWOOD. No, Mr. Chairman.

Mr. WAXMAN. Our first witness today is Mr. William Toby, Acting Administrator of the Health Care Financing Administration. Mr. Toby has held this position since April of last year, and before this appointment he was the HCFA Regional Administrator in New York, for over 15 years.

We are pleased to have you with us, Mr. Toby. As I mentioned in my opening statement, we would like for you to summarize the administration's budget recommendations for both Medicare and Medicaid, since you will not be with us at tomorrow's Medicaid hearing.

Of course, your full statement will be made part of the record. We usually allot 5 minutes for the oral presentation, however, and we would like to give you 10, and hope that will be sufficient for the oral presentation to us.

STATEMENT OF WILLIAM TOBY, JR., ACTING ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION

Mr. TOBY. Thank you, Mr. Chairman. Mr. Chairman and members of the subcommittee, I am pleased to appear before you to address the proposals that constitute the administration's downpayment for reforming our Nation's health care system.

I will present our savings proposals for Medicare part B, Medicaid and Medicare secondary payer. Medicare and Medicaid are a large and growing part of the Federal budget. Over one-half of the projected growth in the Federal deficit in the next 5 years is due to increased growth in Medicare and Medicaid spending. A serious attempt to reduce Federal spending must include curbing their rapid growth.

The administration's proposals are designed to reduce public sector health care spending growth without making significant structural changes to Medicare and Medicaid programs. Any structural reforms in our health care system will be dealt with in the administration's health care reform package, which is due to be released later this spring.

The administration has offered 13 proposals to curb spending for physician services and other components of part B of the Medicare program. Four of the President's proposals are direct adjustments to the way that Medicare pays physicians. These include: reducing physician fee updates in 1994 except for primary care; developing a resource based system for practice expenses under the physician fee schedule beginning in 1997; revising the physician Medicare volume performance standards and the update formulas; and, establishing a single fee for surgery, thereby eliminating additional payments for assistants at surgery.

Our fifth proposal deals with the part B premium. We would continue the premiums as set under current law through 1996. In 1997 and subsequent years the premium would be set to finance the same proportion of program costs as was financed by the 1996 premium. Our sixth proposal would reduce payments for clinical laboratory services. We propose to implement GAO's recommendation to lower the Medicare laboratory fee schedule caps from 88 percent to 76 percent of the median of all fees, and continue to update the revised fee schedules annually by 2 percent.

In addition, the Secretary would be given authority to make additional adjustments in Medicare rates to reflect technological changes, private market rates and other factors. We hope our seventh proposal, to bundle inpatient radiology, anesthesia and pathology payments, will give physicians and hospitals incentives to provide only medically necessary services.

As you know, studies have demonstrated that physicians with ownership interest in clinical labs make referrals at higher rates than non-owners. Our eighth proposal would expand the current clinical laboratory ownership and referral prohibitions to additional services such as physical and occupational therapy, radiology and durable medical equipment.

The administration's ninth proposal includes two initiatives to encourage electronic submission of part B claims. First, we would offer new authorizing language containing a provision that directs electronic claims to be paid after 13 days and all other claims to be paid after 26 days. Second, we propose to charge $1 per paper claim beginning in January 1, 1996.

Tenth, we are proposing a package of reforms relating to durable medical equipment. These include tightening national limits, reclassifying certain items, and restoring the authority of Medicare's contractors to adjust payments based on current prices.

Our eleventh proposal will reduce hospital outpatient department payments from 94.2 percent of costs to 90 percent of costs and will permanently extend the reduction which expires after fiscal year 1995. Twelfth, we propose to extend the current 10 percent reduction in capital related costs for hospital outpatient services to fiscal year 1996 through 1998.

The administration's thirteenth and final Medicare part B proposal is based on studies conducted by the Inspector General which assert that Medicare is currently paying too much for epoetin, a drug used to treat anemia associated with chronic renal failure. We propose to reduce payment from the current rate of $11 per 1,000 units to $10 per 1,000 units.

We also propose making four modifications in the Medicare secondary payer provisions. The first two modifications would extend expiring Medicare secondary payer authorities to secondary payment for disabled beneficiaries who have health coverage through a large group health plan and the IRS and Social Security Administration data match that is used to identify situations where Medicare made a mistake in primary payment. Currently these provisions are to expire in 1995. The administration proposes to make them permanent.

The third modification would make permanent Medicare's status as secondary payer for end stage renal disease beneficiaries who have health coverage through a group health plan for the first 18 months of entitlement. The fourth modification would establish a uniform small employer threshold of 20 or more employees for all Medicare secondary payer populations: aged, disabled, and ESRD.

I would like to discuss the administration's Medicaid cost containment proposals. As you are well aware, Medicaid spending is the fastest growing component of State budgets. Total Federal and

State outlays reached $118.2 billion in 1992, an increase of 25 percent over fiscal year 1991 spending.

The administration has submitted cost saving proposals in five areas, to provide immediate relief to States and the Federal Government for inappropriate or outdated policies. First, we propose to eliminate the enhanced administrative matching rates and, establish a Federal matching rate of 50 percent for all administrative costs beginning 1994.

Next, we propose to restore State's ability to use closed drug formularies, which give States greater flexibility to ensure the effective use of Medicaid funds while providing medically necessary drugs to recipients.

Our third Medicaid cost saving initiative is to tighten asset rules and estate recoveries to provide greater assurance that individuals with substantial personal assets pay a fair share for nursing home care and certain other medical services before they qualify for Medicaid. Third party liability is the fourth area of our Medicaid savings proposals. The administration proposes to expand the current Medicare, IRS, SSA data match to Medicaid and other Federal health programs. In addition, we propose to remove obstacles to getting Medicaid recipients enrolled in private insurance plans and ensure that those plans pay when they are liable.

Finally, in the area of personal care services, we propose to change a drafting error of the OBRA Budget Reconciliation Act of 1990, which mandated that State Medicaid programs pay for personal care services outside an individual's home, effective in fiscal year 1995. A proposed change removes the mandate and restores personal care as an optional benefit.

These proposals are steps we must take to reduce the deficit while we develop options for health care reform. If implemented, these proposals will result in more efficient practices by Medicare and Medicaid providers, reduction in the rate of growth in Federal health spending, and reductions in the Federal deficit. By targeting inefficiencies in the current programs and promoting more cost effective practices, we can enhance cost effectiveness without compromising the quality of Medicare and Medicaid services.

I look forward to working with you on these and related issues. I am happy to answer any questions you may have. Thank you.

[Testimony resumes on p. 22.]

[The prepared statement of Mr. Toby follows:]

STATEMENT OF
WILLIAM TOBY, JR.
ACTING ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

I am pleased to appear before you to address the proposals that constitute the Administration's down payment for reforming our Nation's health care system and reducing public and private health care costs. I am here to present our savings proposals for Medicare Part B, Medicaid, and Medicare Secondary Payer.

Medicare and Medicaid are a large and growing part of the federal budget. Over half of the projected growth in the federal deficit in the next five years is due to increased growth in Medicare and Medicaid spending. Any serious attempt to reduce federal spending must include curbing their rapid growth in costs.

The Administration's Medicare proposals are designed to reduce public sector health care spending growth and the deficit without making significant structural changes to the program. Any structural reforms to the overall health care system will be dealt with in the Administration's health care reform package due later this Spring.

MEDICARE

The growth in the Medicare program is so rapid that the Medicare deficit reduction proposals will not cut total spending. Rather, they will decrease the rate of growth in Medicare spending between fiscal years 1994 and 1998 by two percent annually.

Part B

The Administration has offered thirteen proposals to curb spending for physician services and other components of Part B of the Medicare program.

- **Maintain the Part B Premium as a Proportion of Program Costs.** As you know, the Part B premiums for 1991 to 1995 were set in the 1990 Omnibus Budget Reconciliation Act at levels projected in 1990 to finance approximately 25 percent of Part B program costs. Current law indexes the 1995 premium by the Social Security cost of living increase to establish the 1996 premium. In 1997 and subsequent years, the premium would be set under our proposal to finance the same proportion of program costs as was financed by the 1996 premium.

- **Reduce Payments for Clinical Laboratory Services and Adjust Fees for Technological Change and Market Factors.** A GAO study released in June of 1991 indicates that Medicare fees for laboratory services are excessive and higher than fees from private payers. Therefore, we propose legislation to implement the GAO's recommendation to lower the Medicare laboratory fee schedule caps from 88 percent to 76 percent of the median of all fees. This revised fee schedule would be updated annually by 2 percent -- an extension of the current law established in the 1990 Omnibus Budget Reconciliation Act. Finally, the Secretary would be given authority to make additional adjustments in Medicare rates based on market surveys to reflect technological changes and other factors. We estimate these lab fee proposals will save $5.8 billion over five years.

- **Reduce Physician Fee Updates in 1994 Except for Primary Care.** In 1980, Medicare payments to physicians totalled $7.8 billion. Last year, that number had grown more than four-fold to an astounding $32.3 billion. We propose slowing this substantial growth by reducing the 1994 fee schedule update by two percentage points for non-primary care services. Because the Administration believes more emphasis should be placed on primary care, primary care services are excluded from this proposal and would receive the full fee schedule update. We estimate a five-year savings of $1.7 billion.

- **Resource-Based Practice Expenses Development.** This proposal would move us toward a resource-based system for practice expenses under the physician fee schedule for 1997 -- as recommended by the Physician Payment Review Commission. As an interim step toward such a system, we propose reducing practice expense relative value units in 1994, 1995 and 1996. A cushion on reductions would be provided. The five-year savings for this proposal would be $3 billion.

- **Reduce Physician MVPS and Update "Default" Formulas.** This proposal refines the method to set the Volume Performance Standard and future updates for physician services. Currently, in any year Congress does not set either the target for the rate of increase in Medicare physician expenditures, or the update, default formulas specified in law automatically apply. We propose reducing the target for fiscal year 1994 and thereafter by reducing the amount allowed by the default formula. The proposal would also allow larger reductions in the default update formula.

Currently, only modest reductions in the default MVPS are permitted. This proposal would lower the rate of growth to be more in line with recommendations made by the Physician Payment Review Commission. We estimate this proposal would save $2.1 billion over the next five years.

- Bundle Inpatient Radiology, Anesthesia and Pathology Payments. Giving physicians and hospitals incentives to be cost-conscious, by providing only medically necessary services and eliminating the provision of marginal services, are overall goals of our proposal to bundle inpatient Medicare payments for radiology, anesthesia and pathology services. Payment would be made to the hospital, or its medical staff, which would then make payments to individual physicians. Beneficiary coinsurance would be 20 percent of the bundled payment. We estimate this reform would save $570 million over the next five years.

- **Single Fee For Surgery.** Nationwide data strongly suggest that use of assistants-at-surgery is related to variations in practice styles of individual surgeons rather than the severity or complexity of specific patient cases. Therefore, we propose to make the same Medicare payment for a surgical procedure -- regardless of whether the primary surgeon uses an assistant-at-surgery. As a result, Medicare payment for the primary surgeon would be reduced by the amount of any separate payment for assistants-at-surgery. Exceptions would be allowed, if necessary, for particularly difficult cases. In addition to creating a level playing field between surgeons who do and do not use assistants-at-surgery, this proposal would result in a five-year savings of $510 million.

- **Physician Ownership and Referral.** As you know, studies have demonstrated that physicians with ownership interests in clinical labs make referrals at a higher rate than non-owners. This proposal would extend current clinical laboratory ownership and referral prohibitions to additional services such as: physical and occupational therapy; radiology and other diagnostics; radiation therapy; durable medical equipment; and parenteral and enteral nutrition equipment and supplies. We foresee that extending the physician referral ban will help to reduce unnecessary utilization of these services and, as a result, save $350 million over the next five years.

Electronic Billing Incentive. A total electronic billing system is critical to containing Medicare administrative costs. To encourage electronic submission of Medicare Part B claims, the Administration is proposing two initiatives: First, we would offer new authorizing language to continue a provision included in the FY 1993 Appropriations Act under which electronic claims would be paid after 13 days and other claims would be paid after 26 days. The current provision expires September 30, 1995. Second, we would impose a $1 charge per paper claim beginning January 1, 1996. This lead time would give physicians and suppliers time to adjust their systems or arrange to purchase electronic billing services. Our proposal would also lower limiting charges by $1 to prohibit physicians from passing on the cost to Medicare beneficiaries. We estimate this proposal will save $440 million over five years.

- **Durable Medical Equipment Proposals.** We have designed a package of savings proposals to reduce excessive variation in payment amounts and strengthen administration of the durable medical equipment benefit. Currently, payment for durable medical equipment is based on carrier fee schedules with national limits at the average value across all carriers. Our proposals to reduce payments for durable medical equipment include: tightening the national limits; reclassifying certain items; strengthening the authority of Medicare's contractors to make adjustments to the fee schedules if payment amounts are grossly excessive or deficient based on current price information; and giving Medicare's contractors flexibility to require that the medical need of overused items be demonstrated in advance of delivery to the patient. In addition, the fee schedule for prosthetics and orthotics would be tightened by using the durable medical equipment payment rules with the national median for calculating the limits. Finally, we propose establishing a fee schedule to pay for parenteral and enteral nutrients and supplies, and to pay for parenteral and enteral equipment under the same fee schedule and methodology used for durable medical equipment. We estimate a five year savings of $685 million dollars if these durable medical equipment proposals are implemented.

- **Reduce the Hospital Outpatient Department Payments from 94.2 Percent of Costs to 90 Percent of Costs and Permanently Extend the Reduction, which Expires After FY 1995.** The Administration proposes to extend the current statutory provision that reduces payments for those hospital outpatient services paid on a cost basis. This reduction is now 5.8 percent. Since outpatient services is one of the fastest growing components of the Medicare program, the extension would attempt to counter this rapid growth. Without extending the reduction past FY 1995, we fear that outpatient growth would continue to increase at an extraordinarily high rate without any control mechanism to keep spending in check. In addition, we propose to increase the reduction to 90 percent of costs beginning in FY 1996. This would be consistent with our proposal to reduce payments for outpatient capital, which is also set at 90 percent of costs. Estimated savings over five years is $2.7 billion.

- **Set Payments at $10 per 1,000 Units of EPO.** Currently, Medicare pays $11 per 1,000 units for EPO, also referred to as epoetin, which is a drug used to treat anemia associated with chronic renal failure. This proposal would reduce the amount to $10 per 1,000 units. EPO is unique in that only one pharmaceutical company manufactures EPO, and Medicare currently purchases 90 percent of EPO. Based on studies conducted by the Inspector General and on our reviews, we believe that the current rate of $11 per 1,000 units of EPO is excessive. By reducing the payment to $10 per 1,000 units of EPO, we would virtually eliminate the disparity between Medicare's current payment rate and the actual cost that facilities incur for EPO. Estimated savings over five years are $210 million.

Medicare Secondary Payer

Another $4.5 billion in Medicare savings would be realized through four modifications in the Medicare secondary payer provisions, as follows:

- **Extend Three Expiring Medicare Secondary Payer (MSP) Authorities.** Under current law, the authority for two MSP activities expires at the end of either fiscal year 1995. They are:
  - o Secondary payment for disabled beneficiaries who have health coverage through a large group health plan; and
  - o The Internal Revenue Service (IRS) and Social Security Administration (SSA) data match, in which IRS/SSA data is used in conjunction with questionnaires to employers to identify situations where Medicare made a mistaken primary payment, instead of the secondary payment required by law.

The Administration proposes to make permanent the secondary payment for disabled beneficiaries and to extend the IRS/SSA data match provisions.

In addition, the coordination period for secondary payment for beneficiaries with end-stage renal disease (ESRD) who have health coverage through a group health plan would change from 18 months to 12 months on January 1, 1996 under current law. The

Administration proposes to eliminate this change so that the coordination period would be 18 months permanently. These proposals would result in estimated savings of $3.2 billion over five years.

- **Provide Consistency to Medicare Secondary Payor (MSP) Small Employer Threshold Provisions.** Under current law, employer thresholds for the MSP provisions vary depending on whether the beneficiary is aged, disabled or has ESRD. This proposal would establish a uniform threshold of twenty or more employees, which is the current threshold for the working aged. It would reduce the threshold for the disability provision from employers of 100 to employers of 20 and would create a threshold of employers of 20 for ESRD where none now exists. Other conforming changes and a number of modifications to improve administration of the MSP program would also be made. All components of this proposal yield savings over five years of $1.3 billion.

The proposals discussed above represent the Administration's recommendations for reducing the rate of growth in Medicare Part B spending.

MEDICAID

The Administration has developed several cost containment proposals to reduce the rate of spending growth in the Medicaid program to provide fiscal relief for both the Federal and State governments. Medicaid spending is the fastest growing component of state budgets. Total Federal and State outlays reached $118.2 billion in FY 1992, an increase of 25 percent over fiscal year 1991 spending.

The number of Medicaid recipients served also increased in FY 92 to nearly 31 million due to the economic recession and program expansions. The Administration has submitted cost-saving proposals in five areas to provide immediate relief to States and the Federal government from inappropriate or outdated policies. We estimate that these Medicaid proposals will save about $8.8 billion over the next five years.

- Reducing the Administrative Match. Under current law, the Federal government matches most State administrative costs at 50 percent. For a number of special activities, the government provides enhanced matches, such as 90 percent for the design, development and installation of Medicaid Management Information Systems and 75 percent for ongoing operation of these systems. These incentives have served their purpose and there is no longer a need to motivate States to continue their efforts in these areas. The President's proposal would eliminate the enhanced rates and establish a Federal matching rate of 50 percent for all administrative costs beginning April 1, 1994. This proposal would save $2 billion over five years.

- **Removing the Prohibition on Drug Formularies.** Before 1990, States could use closed drug formularies to limit the drugs they would cover. The Medicaid drug rebate program, enacted as part of the Omnibus Budget Reconciliation Act of 1990, now requires States to cover all drugs of manufacturers who have signed rebate agreements with the Secretary. The President's proposal, which would restore States' ability to use closed formularies, offers States greater flexibility to ensure the effective use of Medicaid funds in providing medically necessary drugs to recipients. The estimated savings from this proposal would be $100 million over five years.

- **Tightening Asset Rules and Estate Recoveries.** The Medicaid statute contains numerous loopholes that enable persons with substantial assets to qualify for Medicaid. This proposal provides greater assurance that individuals with substantial personal assets pay a fair share for nursing home care and certain other medical services before they qualify for Medicaid. It would continue to permit States to recover from estates of deceased Medicaid recipients, but would restore a broader definition of what an "estate" is. The estimated savings from this proposal are $565 million over five years.

- **Child Support Enforcement.** This proposal would remove obstacles to getting Medicaid recipients enrolled in private insurance plans and in making sure that those plans do not avoid their liability to pay. This proposal would be especially helpful to children who could be, but are not currently, enrolled in an insurance plan available through absent parents. Federal savings from this proposal are estimated to be $218 million over five years.

Personal Care Services. The Omnibus Budget Reconciliation Act of 1990 mandated that State Medicaid programs pay for personal care services outside an individual's home effective in FY 1995. Congress had intended that this service be provided at a State's option but, through a drafting error, changed what had always been an option into a mandate. The proposed change removes the mandate and restores personal care as an optional benefit, producing an estimated $5.8 billion savings over five years.

These Medicaid proposals would contribute savings primarily by giving States necessary flexibility in how they structure their long-term care and prescription drug programs. Savings are also derived from encouraging States to improve estate recovery activities and eliminating special administrative match rules.

MEDICARE/MEDICAID

- **Third Party Liability (TPL).** Part of the total Medicare and Medicaid savings mentioned earlier come from this proposal. Both the Medicare and Medicaid programs frequently pay for services that should have been covered by another insurer. Other Federal health programs have similar problems. The Administration proposes to expand the current Medicare IRS/SSA data match to these programs and to the Child Support Enforcement program. A central clearinghouse would be established to coordinate these activities. An additional data element would be added to the W-2 form which would indicate whether the employee had been providing health insurance coverage and whether this coverage was for an individual or a family. This would eliminate the need to contact these employers. The combined Medicare and Medicaid savings from this proposal are estimated to be $1.2 billion over five years.

We must now take steps to significantly reduce the deficit while we develop options for health care reform. If implemented, these proposals will result in more efficient practices by Medicare and Medicaid providers, reductions in the rate of growth in Federal health spending, and corresponding reductions in the Federal deficit. By targeting inefficiencies in the current programs and promoting more cost effective practices, we can enhance cost-effectiveness without compromising the quality of the Medicare and Medicaid services.

I look forward to working with you on these and related issues. I will be happy to answer any questions you may have.

Mr. WAXMAN. Thank you for your presentation. Without objection from the members of the committee, I would like to extend 10 minutes to each member for questions. If that is not a problem, each member will be recognized for a 10 minute period, maximum. If they wish to use less, that's fine.

Mr. Toby, you testified that the administration's proposals will reduce Federal Medicaid outlays by $8.8 billion over 5 years. The estimates we have from CBO place the 5 year reductions at $7.9 billion. That's a $900 million difference. Can you explain it?

Mr. TOBY. As you know, Mr. Chairman, historically the CBO estimates differ somewhat from the administration estimates. We are in the process of re-pricing our proposals, and we expect some changes from the original estimates we provided to you in February.

Some of these differences result from minor policy refinements to the original proposals. As you know, the President's 1994 Budget will be available in early April. At that time we hope to be able to judge the extent of the divergence of the CBO estimates from the administration's.

Mr. WAXMAN. Let me ask you some questions, first of all, about Medicaid. Saturday's Washington Post carried an article describing the administration's proposed cuts in the HHS Inspector General's budget. The article says that in order to accommodate the cuts the IG is: "cutting its pending caseload by 15 percent, eliminating pending Medicaid cases and turning new Medicaid cases over to the States."

What struck me as odd about this is that, as you just testified, the administration is also proposing to reduce the Federal matching rate to the States for State fraud and abuse units from 75 percent to 50 percent. In other words, at the same time you are downsizing the Federal anti-fraud effort and shifting cases to the States, you want to reduce the Federal funds to the States to pursue these cases.

What am I missing here? Is Medicaid fraud down? Is there an honesty epidemic that is sweeping this country? Or, are we on the verge of opening up the Federal treasury to the providers my colleague, Ron Wyden, has called the "buccaneers and scalawags" of the health care industry?

Mr. TOBY. Mr. Chairman, that information in the Post was contained in an internal confidential document that was leaked, which is the part of the OIG strategic plan. As one standing here before you today I wish it hadn't been leaked, but I guess it was.

The first thing I would like to say to you is that this administration is fully committed to reducing fraud, waste, and abuse. We need to recognize that the Medicaid program is a partnership between the States and Federal Government. The States have as much an interest in reducing fraud as the Federal Government does.

Under our proposal about $46 million in Federal funds in 1994 will still go to the States, to operate their fraud control units. They have those units in about 39 States.

Mr. WAXMAN. Is it accurate, that you are proposing to cut the IG staff at the same time you are proposing to cut the Federal dollars to the States to do their job of looking at fraud and abuse?

Mr. TOBY. As you know, Mr. Chairman, the President has decided that across the board there will be a 3 percent administrative cut. That's just uniform, across all agencies.

Mr. WAXMAN. Is it the administration's position that this will not do any harm to the efforts to seek out fraudulent health care activities that charge both the Federal and State taxpayers an enormous amount of money?

Mr. TOBY. We think that this effort will provide a stimulus for States to be very creative, to do a better job. Unfortunately, we know that when there's a lack of whatever amount of funds they think are necessary, they tend to do a better job. I have seen it in my 15 years working in New York State. They do a good job, and it serves as a stimulus to be more efficient.

Mr. WAXMAN. It's the position of the administration that if we give the States less money they will come up with their own additional funds to do the job of seeking out fraudulent abusers.

Mr. TOBY. The position of the administration is that fraud and abuse is an area in which the State and Federal Government have a great deal of interest. The Federal Government both under this administration, of course as you probably know, has involved the Justice Department in reducing fraud and abuse.

Mr. WAXMAN. Rather than debate the point, I think I understand the answer. I would like to move on to some other questions. I am not sure that I agree with the answer, but I think I understand the answer.

Chairman Dingell's Oversight and Investigations Subcommittee held a hearing on Medicaid managed care, at which the General Accounting Office reported on its six State survey. The GAO testified that oversight of Medicaid managed care plans needs strengthening because of the financial incentives to under serve beneficiaries inherent in capitation.

Presumably, this will require more staff resources of both the Federal and State levels. As you know, the Federal Government now provides enhanced matching payments at a 75 percent rate for the kinds of staff and administrative activities that would strengthen managed care oversight, including skilled medical professional personnel and quality assurance.

I asked the GAO at that hearing whether they thought the oversight of managed care plans can be strengthened if Federal funding for State oversight activities is cut which is, of course, the administration proposal. I want to read their answer, and I want to quote it.

"Every State we visited is having difficulty, given the financial situation at the State level, hiring the kinds of staff and bringing on the new expertise and skills and investing in the data systems that they need to run good programs. That's under the current financing. I think it would be just a terrible blow to the States and it doesn't make sense in terms of managing this program or in terms of fraud and abuse."

Again, there is something wrong with this picture. I assume that the administration is supportive of high quality Medicaid managed care. Yet your budget proposes to cut by one-third the Federal resources now available to States to do the oversight that the GAO thinks is necessary to assure high quality in Medicaid managed plans.

I am troubled by this. I would like to know how many fulltime employees does HCFA now assign to assuring the quality of Medicaid managed care? Are you planning to increase the number of HCFA personnel to make up for the inevitable reduction in State quality assurance personnel due to the loss of Federal matching funds?

If not, what assurance do we have that low income women and children will receive quality care from Medicaid managed care plans, particularly since the GAO does not believe that current oversight efforts are sufficient?

Mr. TOBY. Mr. Chairman, at present, HCFA has about 9 persons in the central office and 10 in the regions, all of whom devote at least 50 percent of their time to assuring quality.

For the last 27 years under the Medicaid program, the States have had the lead with respect to Medicaid administration. We are not eliminating funding. We are only reducing the enhanced match. At present, many of the States are conducting quality assurance activities at the 50 percent rate. They are doing a fairly good job. The systems are in place to assure quality.

Mr. WAXMAN. You think it's all going to be OK; we are going to be able to do the oversight.

Mr. TOBY. Yes, sir, I do think so.

Mr. WAXMAN. Let me ask you another question because I am running out of time. About 3 weeks ago I testified about the administration's proposed reductions in Medicaid before the House Budget Committee. I was critical of the proposal to reduce the enhanced administrative matching rates, which was offered by President Reagan in 1986 and President Bush in 1987 and 1989, and which the Congress has already rejected on each occasion.

Mr. Sabo, the Chairman of the Budget Committee, had a very interesting question for me, which I think I ought to address to you. The Washington Post recently reported that Medicaid provider tax legislation enacted by the Congress in November of 1991 enabled New Hampshire to generate an additional $366.6 million in Federal funds for its 1992 and 1993 budgets. About $44 million went to hospitals and the other $322.6 million went to filling the hole in the State budget, according to information provided by HCFA and the State.

The article quoted a Republican State legislator as saying "We're funding our State judicial system, our highway program, and everything else out of a Medicaid loophole." You will remember that the 1991 Medicaid provider tax legislation was negotiated by the Bush administration and the National Governors' Association. I opposed this legislation, although at the time I had no idea that it would be used to spend $323 million in Federal Medicaid funds for New Hampshire to fund its highways and judicial system.

According to the article, interestingly enough, other members did know, including former Senator Rudman and then-Governor Gregg. I can understand why the Bush administration did not find this arrangement too troublesome. After all, the White House Chief of Staff at the time was a former Governor of New Hampshire.

My question is, will the Clinton administration tolerate the use of Federal Medicaid funds to pay for State highways or prisons or courts or education? I see nothing in the President's vision for change or in your testimony this morning, that speaks to this. If we have to cut Federal Medicaid spending and the budget resolution says we must, couldn't we just stop the States from using Federal Medicaid funds to pay for highways, courts and education?

Wouldn't this make far more sense than cutting back on support for fraud and abuse units or nursing home inspections? Do you have any recommendation for us on this point? I will let you respond to the question, and then we will have to move on.

Mr. TOBY. First, Mr. Chairman, I would like to say that we do not endorse the use of Medicaid funds to pay for highways, or for States to balance their budgets, or for States to use funds on other programs. The 1991 provider tax law was designed, as you know better than anyone else, to restrict that kind of use.

New Hampshire, I should mention, set up their system before the new law was passed. At that time they had a relatively free hand to use provider taxes to finance the State share of their programs. The new law makes that much more difficult.

Only certain provider taxes are permissible. In addition. we have a 12 percent limit with regard to how much States can pay to disproportionate share hospitals. We also have a hold harmless provision. That gives us the tools, we think, to restrict that kind of use of Medicaid funds in the future. I think if we continue to monitor this program very closely and we come to a situation like you just described, we will be able to make recommendations to you.

Mr. WAXMAN. Thank you. Mr. McMillan.

Mr. MCMILLAN. Thank you, Mr. Chairman. Just briefly, on the points that you just raised. North Carolina has a situation in which the former Governor didn't choose to put in for matching funds. The new administration is going to change that policy, and put up $100 million which they don't have to spend, and don't have to specify how they will spend. They will get $200 million from Medicaid in matching funds, over which there are no controls.

I am going to do the totally unpolitical thing and make that public, and suggest that North Carolina withdraw its request, as much as I would like to see us get our share. This is comparable to a looting situation, it seems to me we have created it, and it has to be corrected.

A riot starts and everybody jumps into the grocery store and starts taking food, and that's sort of what's going on. It seems to me at some point somebody has to stand back and say no, I am not going to do that. I am going to try and join in enforcing law and order and put a stop to this. That's what I am going to do in this particular case. I think it's a point that we absolutely need to address.

There are no specific proposals in the budget here to deal with this, and I think it should be a part of health care reform. I speak of this with some sensitivity, with an 89 year old mother, who has been in and out of the hospital and nursing homes and I am spending a lot of time on that and learning quite a bit.

It has been said—and perhaps you can confirm this or correct it—that 28 percent of Medicare reimbursements are paid out in the last 4 months of life. Is that substantially correct?

Mr. TOBY. I believe that's true from the study that was done in the New England Journal of Medicine recently.

Mr. MCMILLAN. Is that the most accurate description of the magnitude of it?

Mr. TOBY. The short answer is that I don't know. But for the record, we can certainly get that information and make it part of the record.

[The information follows:]

A new HCFA study, "Trends in Medicare Payments in the Last Year of Life" showed that over a 12-year period, decedents account for an average 28 percent of Medicare spending each year. While per capita payments increased nearly four-fold during this period, the proportion of total dollars spent for decedents showed little change. Even when costs for only the last 2 months of life were considered, the study showed no rise in the percentage of payments.

Mr. MCMILLAN. Do we not have in our considerations with respect to Medicare reimbursements, enough information with respect to standards of practice that would enable us to make judgments about that?

Mr. TOBY. You are raising a question concerning where we tend to be going, which offers one of the best answers to that question. We are trying to determine medical effectiveness. As you know, there is no uniform clinical practice in this country. I mean, medicine is practiced locally. Decisions are made locally.

We are working on outcomes research, and that gives us the only hope that I know of to address that kind of a question.

Mr. MCMILLAN. We will be spending more on that later. I think it's possible to get highly sophisticated on how you approach it. I would suspect that if you got a group of providers together and asked what's normal procedure here, probably in 90 percent of the cases, they would reach a broad range of consensus that would provide a sensible basis for public policy. We get overly sophisticated, and I think the problem goes on and on.

There are standards of practice, obviously. It goes on every day. We make reimbursements based on that every day. To say that this is something that has to be studied and dealt with in the future is an indication of why we have such a major problem in coming to grips with things.

Just to give some personal experience, a physician who is on the staff of the hospital where I had to commit my mother 8 weeks ago, was president of the North Carolina Medical Society. He challenged the society to address the difficult issue of terminal health care, and adopted a Statewide policy on living wills, thinking that would be constructive, which the medical society adopted.

When I admitted my mother I said I wanted to point out that she signed a living will at the suggestion of the State medical society, and I just want that in her record and file during a difficult time. They said, that doesn't make any difference. Same hospital where the doctor practiced, that initiated the policy. I said why not. He said, because on advice of counsel it's not sufficient.

I said, what is sufficient. You have to sign an agreement every 14 days, provided she's not mentally competent, that is labeled something like a non-resuscitation agreement. You have to sign it every 14 days. I said, OK. I consulted with my family and we discussed this previously. I said, I am prepared to do it, but is she mentally competent. They said, we don't know.

What I am getting at is the evasion of responsibility that goes on in this process, even with people who are prepared to assume responsibility. Standards of practice with the proper respect for the wishes of the patient could deal with that. We are sitting around here nickel and diming possible solutions and the President has come up with a number of good ideas, but it's only the tip of the iceberg. Yet, we are not addressing some very fundamental things like terminal health care costs.

To shift for just a minute, would you care to comment any further on that?

Mr. TOBY. I could add, Mr. McMillan, my personal situation with my own mother. I went through this in the health care system as well. I felt that there were a lot of inappropriate services provided to my mother in the last week of her life. Being the Medicare director in New York, I didn't think it was appropriate.

However, Medicare makes the decision for payment based on medical necessity and whether the service is covered. There is substantial variation in practice patterns, as I said before, throughout the country. It is very difficult to get a handle on the situation that you have raised, other than by the Agency for Health Care Policy and Research, which is working on some kind of consensus guidelines for the whole country to use.

Until that is done, I am not very sanguine about the future.

Mr. MCMILLAN. If I could just interrupt there. I think that's quite possible, if you go through a procedure you will get some different opinions about things. On balance, it's possible to achieve a consensus in many cases, and we should maximize that and set that as a reimbursement standard.

I don't want to get too personal on this. In my own case that I was describing earlier we have had two cat scans and one MRI, and one of the doctor's said let's do another cat scan. I said, what are you going to do another cat scan for. You recommended it on the basis of the previous cat scan, that you wouldn't operate.

What do you want another cat scan for? So I know what's going on. What are you going to do if you know what's going on. I wouldn't recommend that we do anything. Those things get sent in, and we pay for them.

Mr. TOBY. As I said, I do think outcomes effectiveness research is the way to go, because that's where we try to get a handle on whether an individual procedure is worthwhile or appropriate.

I think as the Agency for Health Care Policy and Research makes progress in trying to get a consensus on practice guidelines and as the Medicare program looks at the question as to whether or not there should be some relationship between payment decisions and whether a service is effective, I think that will get us where I think you are asking to go.

Mr. MCMILLAN. I think the fact is that we are going to have recommendations here maybe the month after next, that are going to deal with some very complex issues like malpractice reform, like levels of reimbursement, quality appraisal, all of which are going to be based on standards of practice or should be.

I think we are going to be in the soup. This is one of those things where I think the provider community, doctors and hospitals and so forth, can help us considerably by saying here are areas where we can reach broad ranges of agreement that provide a basis for objective sensible action on some of these things. I would simply leave it at that.

A number of the things that you have addressed in your proposal deal with issues like level of co-payments, with issues like percent of premiums paid by the beneficiary group. Just to get this in perspective, is there a history with respect to Medicare with regard to those two issues.

In other words, you can shift the percentage of premiums by wealthy senior citizens and make dramatic budgetary savings. You can make co-payments a fairly common practice in most areas of Medicare. I think you have a few suggestions that would impact that, such as capping laboratory fees. That's not exactly co-payments, but that's going to fall back on the individual.

Could you give us just a little bit of history on that, or is that asking you to reach back beyond your own personal experience?

Mr. TOBY. Traditionally, the premium—at least on part B—has been related to a percentage of program cost, as you know. We intend to continue that relationship and not tie the premium to the wealth of an individual.

I think as we pursue health care reform where everything is on the table, perhaps that issue will be dealt with. I don't know the outcome of that.

Mr. MCMILLAN. Don't you think that the catastrophic bill that we disastrously adopted and rescinded a few years ago created a problem because it didn't deal with means testing. It basically impacted people perhaps with marginal income, and that was the reason that it became politically impossible to do.

Mr. TOBY. I think that this is traditionally one of the most worrisome issues in public policy: how do you distribute the cost for a particular service or for a particular benefit. It's one in which it's very difficult to get consensus.

Mr. WAXMAN. The gentleman's time has expired. Dr. Rowland.

Mr. ROWLAND. Thank you very much, Mr. Chairman. I want to pursue a little bit further, what the gentleman from North Carolina was concerned about. That is, the outright abuse, waste and fraud that we know exists. While we may not know the motives of individual providers in any particular instance, we do know that there are many instances when outright abuse exits.

Do you have any idea in dollar amounts, of what fraud and abuse and waste there is in the Medicaid and/or Medicare system?

Mr. TOBY. The General Accounting Office has issued a number of reports with regard to fraud and abuse in the Medicaid and Medicare systems, particularly in Medicare. I think the figures have ranged from $1 to $2 billion, as I remember the figures over the years.

I don't think anyone really knows exactly how much abuse and how much fraud there is in the system. We know it's evident. We know we have to stamp it out. We think that we are doing a very good job of that in Medicare. Over the last 6 years our payment safeguards have saved the Medicare program about $20 billion. Just in the last year, because of our safeguards, we have had substantial savings as well. We think that as long as we are talking about programs of magnitude of $118 billion as in Medicaid and over $100 billion in Medicare, there are very creative minds out there, always willing to find loopholes.

Mr. ROWLAND. Wouldn't you say in systems that are structured like the Medicaid system is structured, that it is certainly susceptible to being abused and as you say, to look around and find ways to game it and outright fraud.

Mr. TOBY. Yes. That's why we have exceptional systems in place to really detect fraud, waste, and abuse in the Medicaid program. We have a quality assurance system that we use to detect whether or not there is inappropriate utilization and to look at the question of whether or not providers are taking advantage of our program.

Because the Medicare program is locally administered by 82 contractors, decisions on pricing, coverage and medical necessity are made by a contractor. We are not very happy about some of the GAO reports about waste, fraud and abuse, because they have determined that many decisions made by the local contractors have not been correct.

We have basically decided that instances of inappropriate decisionmaking which have led to waste, fraud and abuse, are just not acceptable to us. Because of changes in technology, communications, and information systems, we believe we can do a much better job.

We have decided to move the Medicare program toward national administration over the next few years. We have a Medicare transaction system in which we are implementing over the next several years to take over national administration of the Medicare program. We are concerned that we need to have uniform policies, uniform systems, and make decisions at the national level to get rid of the kind of fraud and abuse that you are concerned about.

Mr. ROWLAND. As the gentleman from North Carolina mentioned what they were doing there in Medicaid, there are now efforts underway in my own State of Georgia which disturb me considerably, in that additional provider taxes are going to be put in place so that additional Federal funds can be coming to expand the Medicaid program in my State. I think it's well established that it is a program that is certainly susceptible to the things that we have already mentioned. While I know there is a cap in statute law relative to the amount of funds that can come back to a State under Medicaid, is HCFA concerned about expansion of Medicaid programs in States because of various innovative ways of getting additional money in the States for matching Federal funds.

Mr. TOBY. Yes, sir, we are concerned. That's one of the reasons we came to the Congress and had a new law passed in 1991. The Provider Taxes and Donations Law was designed to restrict the kind of abuses to which you refer.

I think what you are referring now to is inter-governmental transfers. That is what's happening in North Carolina and Georgia. Obviously, it's permissible under current law. We plan to continue to monitor State activity in this area. We are convinced that the law is inadequate to deal with situations where we feel there are abuses. What's being done in Georgia and North Carolina is not illegal. We will review the policies and, if indicated, we will ask that the statute be changed.

Mr. ROWLAND. You certainly have a formidable challenge before you. I want to change directions just a little bit, and ask something about laboratories and physicians ownership of laboratories.

Last week I was visited by a physician from a small rural community. He's the only physician there, and he has a small laboratory in his office. He told me that he is finding it impossible to comply with regulations of CLIA now, and he is concerned that he will have to close the laboratory and not be able to do the kind of things that he has been doing there, and the patients will have to be referred elsewhere which would be considerably more expensive.

Can you elaborate somewhat on how this may be affecting physicians in laboratories that are in their offices in rural communities throughout the country.

Mr. TOBY. Mr. Rowland, one of the last things I did prior to implementing the CLIA regulation, was to try to be responsive to the difficulties posed by rural physicians. We were very sensitive to the fact that rural physicians ought to have some sort of freedom, at least exemption from some of the educational requirements, to make the services available.

I have not been aware of any national problem posed by rural physicians. However, we will be very happy to look into the situation with regard to the recommendation on future physician referrals, if we can get the specifics of what's occurring. We made an exception for rural physicians, as you know.

Mr. ROWLAND. I thought that was the case, but he has said that he is being asked to comply. That's the reason he came to see me.

Mr. TOBY. In our proposal we make an exception for rural physicians. I would like to get the details of the problem so that I can look into it. We will have our Atlanta office to look into it.

Mr. ROWLAND. I would appreciate that.

Mr. TOBY. As you know, I am from Georgia, sir.

Mr. ROWLAND. Right. You better look after the rural Georgia physicians. Let me ask you one other thing, and that has to do with fees for assistants at surgery. I see that the proposal is not to allow except in particularly difficult cases, fees for assistants at surgery. What is a particularly difficult case?

Mr. TOBY. We intend to look at specific kinds of criteria which we are developing. We will be happy to work with you to get your ideas about the kinds of cases that you think ought to be exempted.

Mr. ROWLAND. I guess when a physician or someone who is qualified to be an assistant at surgery gives their time and time is the way that they earn their living, it becomes somewhat onerous to think that they will not be compensated for that time. I find when it is basically known that it will be possible to receive a fee for assistants and not have any fee splitting or anything of that nature, that assistant fees could be allowed.

Mr. TOBY. Our proposal is designed to focus on discretionary use of assistants during surgery. What we are finding across the country that whether or not an assistant is used depends very much on the practice style of individual surgeons and the customary practices in a given area.

We think the fact that it is so discretionary, in a lot of instances that it's not required. So, that's why the purpose of our proposal is really just to pay for the assistant and reduce that amount from the surgeon's fee. If there is wide variation, the question is, should Medicare be paying for inappropriate uses of assistants at surgery? That's why we have the exception in difficult cases because we recognize in some instances that you mentioned that there may be a need for an assistant.

We will work with you on the criteria, to ensure that physicians in those instances will get paid; that the assistants will be paid, as well as the surgeon.

Mr. ROWLAND. Thank you. Thank you, Mr. Chairman.

Mr. WAXMAN. The gentleman's time has expired. Mr. Greenwood, you are next. There are a number of people standing in the back and I don't know if there are going to be enough members to take these seats. Before you begin, why don't we just see if we can move the seats over to the side if people want to have a seat.

The gentleman is recognized for 10 minutes.

Mr. GREENWOOD. Thank you, Mr. Chairman. The chairman asked you earlier about the proposals for reducing the funding for State fraud and abuse investigation units. It seems logical to me, that if you reduce the expenditures in that regard to a certain point you are going to start to maximize the fraud.

It also seems logical to me, that there's an optimal point in funding fraud and abuse investigation beyond which you don't get results. I wonder if a study has been done to look at the correlation between expenditures for fraud and abuse investigation and the results you get. Is there in fact an optimal level of funding beyond which you don't produce much in results.

Mr. TOBY. That's an excellent question. Basically, because of the fact that there will be a reduction in administrative expenses across the Government, and there will be an impact on fraud units. The current strategy is basically to look in terms of the shortfall in manpower and person power that will be available for fraud units, is to move most of the staff that will be left to areas of higher activity.

There were areas where we had staff where it didn't justify utilization of that staff for the return on investment that we were making. Consequently, we are going to target areas where we think there is a greater opportunity to deter fraud and abuse, and move our resources to those areas.

What I find in terms of reduced match in relation to whether it's having a detrimental effect on States is that the enhanced match is for the development of computerized systems, which are used basically to determine inappropriate utilization of services, and to look at practice patterns to see where there may be fraud. That's why the money was originally made available by the Congress, as you know.

At this stage, 48 States have computerized systems that were fostered by the match; that is the 90 percent for the design and the 75 percent for the operation of systems. Only two States now are without MMIS systems. One of those States will be coming in very soon. Rhode Island will shortly have an MMIS, so that leaves only one State, Nevada. So, with sophisticated computer systems in place in 49 States most States are just reinvesting in an existing computer system. I don't think that's what the Congress had in mind originally. The intent, originally, was to use that enhanced match to develop computerized systems, not to enhance the systems.

States also use those computerized systems to provide data to their fraud control units at the State level. So, that is not going to change with the 50 percent match. They will be able to continue to get the job done, at least in our judgment.

Mr. GREENWOOD. On those State based computerized systems, please tell me a little bit about how they work. Do they take a random sampling of transactions or do they look at a particular percentage?

Mr. TOBY. They do specific kinds of runs, where they look at their expenditures and look at utilization patterns. From that, they get a sense of areas that have the potential for identifying providers or beneficiaries who may be involved in fraudulent activities.

Mr. GREENWOOD. In the area of electronic billing, can you tell me what percentage of providers have the capacity for electronic billing now? Are there solo professionals or rural physicians less likely to be able to participate?

Mr. TOBY. We have overall figures on electronic billing. Under part A, about 84 percent of our claims come in electronically. On part B, it's about 57 percent. By the year 2000 we expect to have 100 percent EMC. There is substantial movement toward a computerized electronic environment where all claims would be submitted electronically. We only are catching up with the private sector for the most part. We are making substantial gains in terms of the program, as you can tell from the statistics.

Mr. GREENWOOD. Is the acquisition of that computerized equipment subsidized at all?

Mr. TOBY. Yes, it has been in the past, particularly on the Medicare side. Of course, we provide very generous funding.

Mr. GREENWOOD. For the individual physicians and practitioners, is that subsidized as well?

Mr. TOBY. We have not provided subsidies for the physicians on electronic billing. Their incentive has been to get faster reimbursement, obviously.

Mr. GREENWOOD. You think there's enough built in incentive right now?

Mr. TOBY. For faster reimbursement, yes.

Mr. GREENWOOD. The dollar fee, I assume, is going to be a disincentive to not doing it.

Mr. TOBY. We provide some financing for the software.

Mr. GREENWOOD. Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you very much, Mr. Greenwood. Mr. Wyden.

Mr. WYDEN. Thank you, Mr. Chairman. I am still puzzled on this matter of how, if we cut the anti-fraud efforts at both the Federal Government level and the State level, that is going to lead to stronger anti-fraud effort. Maybe I am missing something. Maybe this is metaphysics or fraud fighting or something like that. Maybe we can start this by your telling us.

On page 15 you say that inefficiencies in current programs are going to be what you look for in terms of saving. What are the current inefficiencies and redundancies in the anti-fraud area that warrant these kind of cutbacks in the Federal anti-fraud effort and the State anti-fraud effort?

Mr. TOBY. We find that in States that have computerized systems to determine whether they still need staffs as large as they have now. There are incredible technological advances occurring. What we find is that many times States don't take advantage of these technological advances. They continue with the same amount of staff to do what computers were brought in to allow them to do more efficiently.

We also find that States can be much more diligent in terms of targeting areas. For example, we are spending $7 billion a year on drugs in the Medicaid program, and we now have drug utilization review systems. All of these offer incredible opportunities for States to be more efficient. That's what we were getting at.

Mr. WYDEN. Have you all done a State by State assessment of these anti-fraud efforts so that we could see your analysis of these inefficiencies at the State level?

Mr. TOBY. The Inspector General's office works very closely with the State Medicaid agencies. HCFA doesn't do this, as you know. That's not our responsibility. Our job is to finance health care and to work with the Inspector General's office to ensure that our policies are not leading to fraud and abuse. The States are asked to do annual reviews of the effectiveness of their fraud units.

Mr. WYDEN. I understand that. It's that if the focus is going to be on inefficiencies in current programs, particularly when this anti-fraud effort is so important and I know the administration's commitment to it, I just think great care has to be paid before we cut money at both ends of the spectrum. There are cuts at the Federal level and cuts at the State level. I have to tell you, that I don't see how you can make these kinds of very strong cuts and just say magically that this is going to lead to more efficient anti-fraud programs.

Mr. Chairman, perhaps we can get the Inspector General to give us his assessment of where the States are inefficient. I am greatly concerned about this effort, and will hope that we can look at it more carefully before we go ahead with these kinds of cuts.

Mr. WAXMAN. If the gentleman will permit, we will submit a request to the Inspector General, and we will leave the record open to insert that information.

Mr. WYDEN. Let me ask you also about another matter that concerns me, and that is the proposed cutback in the Federal share of nursing home inspection. My concern here—I think it's a cut from 75 to 50 or something like that. My concern here is that what's most likely to happen if you have a cutback of that nature, is that substandard nursing homes are likely to go longer before they get inspected.

We would have a situation, again, where vulnerable people could be put at risk and not have the kind of oversight and monitoring. I don't know what the administration's objective in this area has been.

Mr. TOBY. With regard to our proposals, we have a proposal to reduce the return on equity for nursing homes, which has nothing to do with the beneficiaries or recipients. I would only say that protecting the health and safety of Medicare beneficiaries in nursing homes is one of the highest priorities of the Health Care Finance Administration.

The regional offices have an excellent record of protecting those beneficiaries and Medicaid recipients in nursing homes. We have a very detailed standards on nursing home oversight including the timing of reviews. I have spent since 1968, my entire professional career in New York, working to provide that oversight, using these detailed standards. I think we had one of the best records in the country.

I know my counterparts in other regional offices spend a great deal of time and effort. We close a lot of nursing homes. If there's anything that we do right, I think it is our record of excellent oversight with regard to nursing homes.

Mr. WYDEN. How are those objectives, and they are laudable, promoted by cutting the Federal share. I can't imagine when you were in those positions, that you at the State level would have been cheerleading in a reduction in the Federal share. It is something that, again, maybe I am missing and maybe these are not correct numbers. But I know that those who are advocating for the patients—and we are going to hear from them tomorrow—are very troubled by the prospect of Federal share for these inspections going down.

As I look at it, given the fact that resources are so scarce at the State level, I think what we are going to see are more substandard homes staying out there longer, without any likelihood that they are going to be inspected more promptly.

Mr. TOBY. I can assure you, Mr. Wyden, that this administration will not allow deterioration in nursing home quality standards. We will be vigilant, to ensure that that does not happen.

Mr. WYDEN. I think your intentions are good. I know that they are good. Again, it's like the anti-fraud effort. You look at these budgets and you ask where the inefficiencies are, and it seems hard to locate some of them. Yet, you see big chunks of money vanishing into other areas, and it becomes tougher to see how we are going to obtain the objectives we are interested in.

We will be anxious to work with you in that regard. Mr. Chairman, thank you.

Mr. WAXMAN. Thank you, Mr. Wyden. Mr. Upton.

Mr. UPTON. Thank you, Mr. Chairman. I thank Mr. Toby for coming this morning. I would like to follow up a little bit on some of Mr. Greenwood's questions with regard to electronic billing.

Prior to this fiscal year, was there an incentive by HCFA to pay claims by 13 days if they filed electronically? The pretty good statistics, I think, are those numbers that you cited to Mr. Greenwood, 84 percent for part A compliance and 57 for part B. I know that the fiscal year 1993 appropriation bill created an incentive to pay within 13 days if they were able to file electronically.

Was there an incentive prior to this fiscal year?

Mr. TOBY. The short answer to that, sir, is no. Over the years, Congress has set specific floors for HCFA to follow, 13 to 26 days. We have vigorously and aggressively carried out that authority from Congress. This is the first time that we will have this requirement.

We find that we are experiencing a substantial increase and I should say dramatic increase, in electronic claims. I think part of this is because we are in an environment of great technological breakthroughs. The health care industry, of course, is playing a major role in this area.

Mr. UPTON. Would you say then, that the early returns 6 months into the fiscal year in fact—what were the numbers in fiscal year 1992 as an example, compared to these 84 and 57 percent. Do you have a ballpark number in terms of the compliance?

Mr. TOBY. I don't have one.

Mr. UPTON. Dramatically, would you say two-fold?

Mr. TOBY. Well, I would say it would be a substantial increase.

Mr. UPTON. I just want to know what your relative definition of substantial is.

Mr. TOBY. As I said, this calendar year we have seen a dramatic increase in electronic claims. In December we had an increase of about 57 percent. In January it was 67 percent. So, it continues to increase.

Mr. UPTON. Has HCFA been able to keep up its end of the bargain, in that being returning the payments within 13 days?

Mr. TOBY. I think——

Mr. UPTON. Has it in fact accelerated your payments?

Mr. TOBY. Yes. I would say that the record would show that HCFA has been paying fairly fast. If we were not, you would have heard about it.

Mr. UPTON. Do you expect that the administration in their budget submission which is going to be released next month, will continue the $1 charge for those physicians and others that file by paper?

Mr. TOBY. That is in the proposal, the $1 charge, as an incentive.

Mr. UPTON. I think you had indicated that you—let me move on. I have a question with regard to tightening asset rules in estate recoveries. On page 13 of your testimony you indicate that you would continue to permit States to recover from estate's of deceased Medicaid recipients but would restore a broader definition of what an estate is.

Can you elaborate on that a little bit?

Mr. TOBY. We are working out the details on that. The basic issue here is that the Medicaid program was designed to be the last resort payer of medical services for people. We are deeply concerned about the fact that there are a lot of individuals with income and resources much greater than was intended by the original creators of the Medicaid program.

We think that significantly increases the amount of spending in the Medicaid program, and we see a need to tighten that. A specification will be coming forward and we will be very happy to hear any ideas you have to make it even better.

Mr. UPTON. I will look forward to seeing that proposal. The last question that I have, I know that the administration proposes to base payments for the direct cost of graduate medical education on a national average per resident amount, and would give greater weight to primary care residents.

What is going to be the impact in terms of reduction of payments for non-primary care residents?

Mr. TOBY. I think the basic problem here is that we don't have enough primary care residents in this country. What we are trying to use the financial leverage of the Medicare program to really turn this around if we can over the next several years. What we have been able to achieve with Medicare in the last 27 years has been to produce more specialists than this country needs.

By giving these academic medical centers a match to train primary care physicians, we expect them to produce more primary care physicians and reduce the number of specialists. That's the intent of our policy.

Mr. UPTON. Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you, Mr. Upton. Mr. Kreidler.

Mr. KREIDLER. Thank you, Mr. Chairman. As one of the new members of this committee from one of the States out there who learned how to work the system with taxes on the providers, as a member of the State Ways and Means Committee and Health Committee, it is one of those very tempting items to look for, helping to lessen what is certainly as you pointed out so aptly, Mr. Toby, the fastest growing area of State expenditure is the Medicaid program.

As members, as the gentleman from North Carolina suggested, would contact their State legislatures and urge them not to follow such practices, it's very difficult, given the kind of fiscal constraints the States face, unless the law is changed, just because of the pressures that exist. Certainly, as the money goes into the general fund, whether it's used for highways or for our Medicaid match, it really is dollars here and dollars there. It's all coming out of the general fund.

We had more than an ample increase in our Medicaid expenditures to the State, to be in excess of what we were taking in from any maneuvering with the Medicaid reimbursement system.

I think this speaks very keenly, as I said earlier, of the complexity of the system that has evolved and the problems that we have, why health care reform is so absolutely essential, and why we have to move toward some kind of capitation reimbursement in some way or another. I think that looking very closely at group and staff model HMO's is an example of that, that certainly makes a great deal of sense.

One of the questions that was just asked dealt with reduced hospital outpatient payments, from 94.2 percent to 90 percent of cost. As you know, the 20 percent co-payment that patients pay for outpatient hospital services is based on the hospital's charge rather than the Medicare approved amount, which means beneficiaries often pay more.

Wouldn't that problem become worse, if we reduced the Medicare payment to the hospital still further? If we are going to do that, how do we keep the hospital from shifting costs further to Medicare patients?

Mr. TOBY. As you know, the outpatient area in terms of cost and expenditures, is one of the fastest growing elements within the Medicare program. We expect that over the next several years the cost probably is going to increase by 22 percent.

We are very much concerned about how this would increase the co-insurance that Medicare beneficiaries pay. We are preparing a report to Congress on outpatient costs and the outpatient system. We have been asked to develop a prospective payment system for outpatient cost which would basically resolve the issue. At least in terms of the proposal we have, for co-insurance.

We think that the coinsurance problem is more of a structural problem and would be better addressed through health care reform. Nevertheless, we are preparing a report to Congress. The details will be in that report, which the Secretary will be sending forward.

Mr. KREIDLER. You are preparing to introduce or propose legislation, that would go to prospective reimbursement for hospital outpatient services at this time, and would prefer to keep that part of overall health care reform?

Mr. TOBY. We will be sending to the Congress a report, as the Congress directed us to do, recommending at least an outpatient prospective payment system. We are obligated to do that. In that report will be, obviously, some ideas about how to handle the co-insurance.

My basic point is that since it's a structural problem we think it may be best handled through health care reform, since we have such a consensus that we need to do something about health care reform.

Mr. KREIDLER. When could we anticipate seeing that report?

Mr. TOBY. It's in clearance now.

Mr. KREIDLER. Shortly, then?

Mr. TOBY. We hope very soon.

Mr. KREIDLER. I understand the idea behind the proposal to raise payments to hospitals for primary care residency training and to reduce it for specialist training, but I don't understand why Medicare won't pay for residency training in non-hospital settings like free standing clinics affiliated with medical schools.

If we could extend these payments to non-hospital settings without increasing total Medicare costs, would the administration support that?

Mr. TOBY. We are currently working on this and addressing this issue through health care reform.

Mr. KREIDLER. One of the proposals would convert the Medicaid personal care coverage from a mandate to the States to an option, as I understand it.

Mr. TOBY. That's correct.

Mr. KREIDLER. How many States do you estimate would drop this service or not offer it if it were not a mandate?

Mr. TOBY. Prior to the error that was made in drafting OBRA 90, it was an option for States. As you know, the effect has been now to make it a mandatory service. I don't know exactly whether any

State would drop it. They had that right before, and many States provided the service.

I think there's a relationship to the service that most States see to keeping people out of nursing homes. States are grappling with Medicaid being 14 percent of their budgets. I can't imagine States wanting to drop this as a service. We are merely asking that it become an optional service as it has been for most of the life of the Medicaid program, and not be mandatory.

We think an error was made. No State or individual would be affected by this budget proposal. The OBRA 90 provision hasn't become effective yet.

Mr. KREIDLER. I am curious as the discussion goes on about fraud and abuse. How much in your estimate is attributable to the—perhaps scheming isn't the right word—how much of it is due to the fact that Medicare and Medicaid do not pay usual and customary costs? Often adjustments are made in budgets and so forth to try to make up for this less than 100 percent reimbursement, as a portion of the total picture of fraud and abuse that may occur in the system.

Mr. TOBY. I don't think there are any statistics that would give us a sense of that. There's no way for us to get information to give us a sense of the magnitude of that. I find, of course, that there is cost shifting. There's no question about it.

I think proPAC has made the point, that as Medicare does a better job at pricing there's a lot of cost shifting to private insurance companies. We know that takes place. We just would hope that the other sectors become as efficient as Medicare and we can get rid of a lot of the inefficiencies.

Mr. KREIDLER. You must have some kind of estimate from the cases where recovery is sought or charges are filed, usually recovery I would assume, as to how much of that would be attributable to a deliberate attempt to kind of game the system and to make up for lost revenue, as opposed to a more deliberate attempt to make a profit at the expense of the public.

Mr. TOBY. Right. Our entire payment safeguard program goes to the heart of your question. I mean, that's why we have payment safeguards in place. As I mentioned, over the last 5 years I think we have saved $5 or $6 billion in this way. That gives you some sense of payment that otherwise would have been made. The handle we have to control this is through institutional providers. We don't know of any real major problems in that respect.

Since this responsibility basically rests with the Inspector General's Office, in order to gain a better insight, I would direct you to the Inspector General's office on fraud and abuse.

Mr. KREIDLER. Thank you very much, Mr. Toby. Mr. Chairman, I, with Mr. Wyden, would like to see if that couldn't be part of our request to the Inspector General.

Mr. WAXMAN. We will request that information. Mr. Slattery.

Mr. SLATTERY. Thank you, Mr. Chairman. Mr. Toby, does the administration support correcting or dealing with this arbitrary reduction in physician payments during the first 4 years of billing? Congress, in previous years, has passed a correction, and last year that was vetoed as part of the tax package.

I am just curious, does the administration support changing that procedure?

Mr. TOBY. As of now, sir, we have not taken a position.

Mr. SLATTERY. You haven't taken a position, OK.

Mr. TOBY. Not as of now.

Mr. SLATTERY. Tell me about the EACH RPCH regulations and what's going on with them. Do you know anything about that yet

Mr. TOBY. We made a number of grants last October. We see this as a very important element of our strategy for providing services in rural areas.

Mr. SLATTERY. What is the status of promulgating the regulations that we need to get the word out to the hospitals and communities around the country; do you know what the status of that is?

Mr. TOBY. No, I do not. We would be happy to get an answer for that.

[The following response was received:]

The final regulations for the EACH/RPCH program are in final review.

Mr. SLATTERY. Another concern that I have is the whole issue of qualified Medicare beneficiaries and the question of whether we are getting the word out to these people that might be eligible for special treatment under this program.

Mr. TOBY. There are about 14 million people that we think are eligible. We have worked very closely with the Social Security Administration to identify potential qualified Medicare beneficiaries. We have done mass mailings. We believe we are beginning to make more progress in trying to reach such individuals.

Of course, when we find them, these individuals have to meet certain eligibility thresholds and certain asset requirements. But we are trying very diligently to reach them.

Mr. SLATTERY. A broader question that is related to this overall issue of cost and how we can more efficiently deliver health care services in this country is the question about just the overall paperwork that hospitals and providers of all kinds are dealing with.

Tell me, if you will, what HCFA is doing to really look at this broad issue of paperwork as we deal with this issue of comprehensive health care reform. What are your ideas. What is HCFA doing to really look at the paperwork burden that we have put on providers with an eye toward reducing it, in addition to the things that we have all talked about generically about reducing or utilizing for example electronic billing and this sort of thing.

Do you have any other ideas that you are looking at?

Mr. TOBY. We think that there are a number of things. One, of course, is to move toward a total electronic environment. In order to get some help on our proposals, we propose a $1 charge for each paper claim submitted.

Mr. SLATTERY. Do you have any idea how much it's going to cost a provider to get the electronic equipment in place in Sceotyville America that will enable them to avoid the $1 fee that you are talking about?

Mr. TOBY. My sense is that we are not the only insurance company that physicians and other providers deal with. They deal with the private insurance system as well. We are only 25 percent of the business. My sense is that providers have an incentive to electronically submit claims which is that they will get paid faster. That's a big incentive.

Mr. SLATTERY. I am just curious though, as we set up these systems are we going to be talking about imposing a cost on a provider in Elkart, Kans. that's $10,000 for his office or is it $100,000.

Mr. TOBY. Companies provide a billing service for less than the $1 per claim. The software is not terribly expensive. Over the last year in particular, HCFA has worked very closely with providers to give them every support necessary to submit their claims electronically.

It saves them money in the long run, it's a service enhancing administrative improvement for the whole system. We have, in addition, taken extraordinary effort to get the hassle out of our interaction with the physician submitting claims. You may be aware that the American Medical Association and, the ASIM have commended HCFA for the extraordinary work we have done in getting rid of administrative hassle.

Nevertheless, we are processing over 650 million claims a year. It's an incredible environment. I think within that environment, we are very sensitive to making that process as hassle-free as possible.

Mr. SLATTERY. The bottom line is though, you don't know what we are talking about in terms of an actual cost to a provider out there to make this investment in the equipment that is needed. I mean, I was just curious.

Mr. TOBY. We don't collect that information at all. We don't think it's a substantial cost.

Mr. SLATTERY. One other question I had, somewhat unrelated to what we are talking about but I contend related, is the whole question of antitrust problems with the health care delivery system, especially with hospitals.

Has HCFA really looked at this? Have there been any conversations between HCFA and the Department of Justice, about the need for some antitrust legislation similar to what I have introduced, to help clarify the environment that hospitals are working in?

Mr. TOBY. About a year ago, we had a Departmental task force that worked with the Justice Department on this. We are still reviewing the recommendations some of which have now become part of the health care reform effort.

Mr. SLATTERY. Can you be more specific in terms of, does HCFA believe there's a need for antitrust legislation?

Mr. TOBY. The issue tends to be larger than HCFA. It's a national structural problem within the health care system in this country. It's being handled as part of health care reform, and the President will be submitting his plan in May.

Mr. SLATTERY. So, we are going to wait to see what's in that plan in May with regard——

Mr. TOBY. I am afraid you will have to wait and see the plan, yes.

Mr. SLATTERY. Mr. Chairman, I appreciate your being here today. One of the things that I think is very important for us all to keep in mind—and you may have mentioned this in some of your earlier testimony—as we make these changes in an attempt to find $62.6 billion in Medicare and Medicaid savings and about $52 billion in Medicare, what's really phenomenal when we are talking about this is that we are really just talking about slowing the annual increase in Medicare from 12.3 percent to 10.5 percent, the annual increase in Medicaid from 14.2 percent to 13.8 percent.

That's really what we are trying to achieve in this overall effort. It's pretty incredible, when you start looking at the kind of programmatic modifications that are needed just to come up with the money to make that minor sort of macro change in the increase level that we are dealing with.

You have a tough task over there. I appreciate your being here. Thank you, Mr. Chairman.

Mr. TOBY. Thank you, Mr. Slattery.

Mr. WAXMAN. Mr. Toby, we do appreciate your being here. Some of the members may have additional questions, I know I have additional questions I want to submit to you in writing for you to respond in writing for the record.

Mr. TOBY. Thank you, Mr. Waxman.

[The responses to Chairman Waxman's questions follow:]

RESPONSES TO SUBCOMMITTEE QUESTIONS BY WILLIAM TOBY, JR., ACTING ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION

Question.—As you developed proposals for reducing outlays in physicians' services, did you consider delaying the update—for 6 months—rather than just reducing the update for non-primary services?

Answer.—We did not consider delaying the physician update for 6 months. A delay for 6 months would achieve savings only in fiscal year 1994 and not in the out-years. Thus, a 6-month delay would not contribute to a permanent reduction in the Federal deficit.

Question.—You have recommended adjusting the practice overhead component of some doctor's fees in preparing for a resource-based practice component beginning in 1997. What services would you specifically exclude from these adjustments, if any? And, are these exclusions assumed in your estimates?

Answer.—Our proposal would exclude radiology, anesthesia and pathology services performed on an inpatient basis since those services would be covered in our proposal to bundled payment proposal. Our resource-based practice expense proposal also excludes services which have no work relative value units. These are primarily the technical components of services.

Question.—Could you give us any additional details on how you would calculate the new payments you are proposing for radiology, pathology and anesthesia services provided to hospital inpatients?

Answer.—Our proposal would bundle Medicare payments for radiology, anesthesia and pathology physician services provided in the inpatient hospital setting into a fixed add-on payment per hospital DRG. Payments for anesthesia services furnished by certified registered nurse anesthetists (CRNA's) would be incorporated into the fixed payment per discharge. We would establish the fixed payment by calculating the national average amounts currently paid for all Medicare patients who are hospitalized for each of the DRG's. The average payments would be adjusted by the physician fee schedule geographic adjustment factor. The fixed payments per hospital or to its medical staff which would then make payments to individual physicians. No extra-billing would be permitted.

Question.—And, finally, could you give us an idea of the basis for granting exceptions to the single surgical payment, and who would make those judgments?

Answer.—Our proposal is designed to deal with the discretionary use of assistants-at-surgery. There is extensive geographic variation in the use of assistants-at-surgery. For example, assistants are billed in 26 percent of surgeries in the San Francisco Region and in 23 percent of surgeries in the Seattle Region. In contrast, assistants are billed in 5 percent of surgeries in the Philadelphia Region, 7 percent in the Chicago Region, 9 percent in the Kansas Region and 13 percent in the New York Region. In addition, in 21 percent of cases for which Medicare paid for an assistant-at-surgery, the assistant was a general practitioner, family practitioner or internist. These differences strongly suggest that use of assistants-at-surgery is related to practice styles of individual surgeons and customary patterns in local areas, rather than the characteristics of specific patients such as severity. No evidence exists that the use of a physician as an assistant-at-surgery leads to a higher quality outcome.

At the same time that we propose to eliminate incentives that encourage the use of assistants-at-surgery in discretionary case, we propose to create exceptions for procedures or cases where assistants-at-surgery are needed. In these cases, we would continue to make a separate payment to the assistant-at-surgery without an offset to the primary surgeon's payment. We propose to give the Secretary authority to specify surgeries or situations that our proposal would not apply to. These could include cases where the skills of another surgeon may be needed such as where complications might be anticipated (e.g., operating on a patient multiple complications or a patient with known bleeding problems), or procedures that cannot be performed by a single surgeon (e.g., major neurosurgery, extensive tumor involvement, complex vascular abnormalities or highly complex procedures).

Mr. WAXMAN. Thank you for being here. Our next witness is Dr. John Eisenberg, a Commissioner on the Physician Payment Review Commission, since its inception in 1986. Dr. Eisenberg is currently chairman of the Department of Medicine at Georgetown University, and has written and lectured widely on physician payment policies.

We are pleased to have you with us today, and have the benefit of the Commission's consideration of these Medicare proposals. Your prepared statement will be in the record in full. We would like to ask, if you would, to limit the oral presentation to 5 minutes.

STATEMENT OF JOHN EISENBERG, COMMISSIONER, PHYSICIAN PAYMENT REVIEW COMMISSION

Mr. EISENBERG. Let me say by way of introduction, Mr. Chairman, I am pleased to be here. I am accompanied by Loren LeRoy, who is Deputy Director of the Commission. We will focus our comments on Medicare, and we will respond to the recommendations in the President's budget.

I will say as an aside, that today there will be delivered to your office, the 1993 report from the Commission, that does provide some background to some of our deliberations and our response to the President's budget. I won't go into that today. I think in the oral presentation I will just focus on a few of the issues, and then respond to the questions that you have.

The first is a complicated but very important issue, and that is the resource based practice expense and the phase-in of the way in which physicians should be paid for the costs that are incurred in running their offices. The administration has proposed a transition to a policy that would reduce practice expense relative values for those services for which the ratio of the practice expense to work is high, and the number of 110 percent has been chosen.

The Commission has been working on this, as you know, and we have applied some industrial engineering methods to try to understand better what the practice expenses are. That work is ongoing.

In our 1993 report you will see that we recommend a transition to a resource based practice expense that would occur beginning in 1997. The administration proposal accelerates that and moves it forward. We do have some concerns about the specifics of that proposal. One is that it would cause a substantially large reduction in certain services without a substantially large reduction in others, so it's relatively asymmetrical in terms of the direction and the magnitude of those changes.

For example, there would be a 32 percent reduction in diagnostic services, a 32 percent reduction of what the eventual reduction would be. For global surgical it would be 18 percent of what the ultimate change would be. It's not really symmetrical, and we are concerned about that. Some services would be cut even below what we think their ultimate resource base practice expense would be, using this methodology.

We are also concerned that by taking all of these reductions from the expense side, that it would potentially distort the resource base relative value scale, at least in the short term.

Our alternative proposal is that you consider looking at the resource based practice expenses only for those services that are provided outside of the office, because it's those where we think that the changes are going to be ultimately needed. Our calculation is that that would provide you with about 90 percent of the changes that would be included in the President's proposal.

We propose second, that you consider in years 2 and 3 of the transition to a resource based practice expense, and ask the Health Care Financing Administration to substitute screens that are based on some of the methods that we have been working on that we would be happy to work with HCFA in developing further.

Third, that we work towards the date of 1997, so that at that time we move to a full resource based practice expenditure system that is based on methodology that would be worked out in the meantime.

The second largest issue is direct medical education expenditures. The President has proposed a per resident payment that would be at the national average, and that more would be paid for primary care residencies through a weighting scheme. We agree, in principle. We agree, that a prospective amount ought to be paid. We are concerned that there might be some geographic variations that need to be looked at. We do think that the average amount could be set below the current average amount because of the work that has been done by HCFA in reevaluating some of the cost reports and some savings could be obtained there.

We are concerned though, about the weighting factor. We recognize that many of the primary care residency positions are unfilled or they are not filled by U.S. medical graduates. In my particular field of internal medicine only 53 percent this year were filled by U.S. medical graduates.

We are not convinced, that what we need is more positions. We do think though, that we need more primary care physicians. We would like to work with the Congress and HCFA to develop a mechanism where we think the desired effect would be more likely to occur. In our current report we have a proposal which lays out a rather extensive plan, which would enable the Congress to get towards a system of encouraging primary care residencies of high quality while not pulling the rug out from under the necessity to train high quality specialists in those areas, where we will certainly need them in the future.

We can go into more details. I would be happy to comment on your questions regarding the update and ways in which the update might be modified, or any of the other issues in the President's budget that you would like to deal with.

[The prepared statement of Dr. Eisenberg follows:]

STATEMENT OF JOHN EISENBERG COMMISSIONER,

PHYSICIAN PAYMENT REVIEW COMMISSION

Mr. Chairman, I am pleased to come before you to present the Physician Payment Review Commission's comments on the President's budget proposals that relate to physician payment under Medicare. Due to the timing, the Commission had to do a lot of its work by telephone. Although this posed less of a problem in considering proposals in areas in which the Commission has been actively working, in others our comments must be general, pending further opportunity for Commission discussion.

As in previous years, the Commission will not attempt to advise you about the overall magnitude of cuts in physician payment. Instead, we take as our assignment the following: if the Congress should decide to reduce spending for physicians' services in the Medicare program, how can that be done in a way that is most consistent with long-term policy goals.

The Commission has developed comments on one proposal to revise hospital payment (direct medical education) and seven proposals to revise physician payment.

REFORM MEDICARE PAYMENTS FOR DIRECT MEDICAL EDUCATION COSTS

The President has proposed revising the payment method for the direct costs of graduate medical education (GME). Currently, Medicare makes payments under Part A to hospitals for direct costs including residents' stipends and fringe benefits, faculty salaries, administrative expenses, and allocated institutional overhead. These payments are paid to teaching hospitals in addition to DRG payments and are based on hospital-specific per resident costs from the 1984 or 1985 cost-reporting years, updated for inflation.

The President's budget proposal has two components. First, it would replace hospital-specific calculation of per-resident payments with a GME payment based on a national average per resident amount. Second, through weighting, it would pay more than this amount for primary care residencies and less for others.

Prospectively Set Amount. The Commission will recommend a prospectively-set per resident payment in its forthcoming *Annual Report to Congress* as part of a comprehensive reform of graduate medical education. Hospital-specific calculation of payments under the current method has led to substantial variation in payments across hospitals, from a low of $11,000 to more than $100,000 per resident. This variation reflects differences in accounting practices, payments to supervisory physicians, and differences in efficiency, rather than inherent differences in the cost of training.

The Commission recommends that the prospectively set amount be less than the average of current payments, with the difference reflecting the results of past HCFA audits that have identified payments that were not appropriate. The amount should be uniform except for geographic variation determined by the physician work component of HCFA's geographic practice cost index (GPCI). HCFA could be given the authority to vary the prospective payment on the basis of year of training and specialty if supported by data on costs.

Weighting. We estimate that the President's proposal for weighting would increase the average payment for primary care residents by 12 percent, while reducing payment for other residents in their initial training period by 35 percent and for all other residents by 53 percent.

Although the Commission supports the goal of increasing the proportion of physicians trained in generalist fields, it does not consider weighting proposals to be the most effective means to achieve that goal for several reasons. First, creation of additional residency positions in primary care appears unnecessary because there are many existing unfilled slots in these fields. Second, weighting would likely not have a large enough financial impact on hospitals to induce significant reductions in specialty residency positions. Third, despite the current call to increase the proportion of generalists, the nation will continue to require well-trained physicians in all specialties. Paying substantially less than the costs of specialty residencies may not be a wise policy over the long term. The Commission favors limiting the number of positions funded, but funding each of those adequately for the full length of training.

The Commission's *Annual Report to Congress* describes a comprehensive policy for financing graduate medical education that is intended to result in a system of graduate medical education that is more responsive to societal needs. Briefly, this policy includes:

- a congressionally set limit on the total number of residencies to be funded, for example, U.S. medical graduates plus 10 percent;
- a federal body that, using both objective data and input from interested parties, would determine the distribution of these slots by specialty;
- decisions by accrediting bodies to select those residency slots to be funded on the basis of educational quality;
- payments for the direct costs of GME to approved residencies from a national financing pool to which all payers would contribute a percentage of premiums or payments for medical care services; and
- mechanisms to provide transitional financial relief to teaching hospitals that lose residents but still must meet essential service needs.

While conceived as a possible component of health system reform, the Medicare elements of the policy would reduce outlays. Reductions would come from making direct medical education payments for fewer residents, from a lower per resident amount (described above), and from lower ratios of interns and residents per bed in the formula to compute indirect medical education payments.

REDUCE PAYMENT RATES FOR ALL SERVICES EXCEPT FOR PRIMARY CARE

The Administration is proposing a 2 percentage point reduction for all services except primary care (mostly office visits). As we understand it, the proposal would not suspend the process for setting the conversion factor update though the Volume Performance Standard (VPS). Rather, it would subtract 2 percentage points from whatever update was determined.

This proposal differs from an across-the-board cut by exempting primary care services. The Commission made such a distinction in its budget recommendations in years prior to enactment of the Medicare Fee Schedule and the Congress provided higher updates for primary care services in OBRA87 and OBRA89.

The context now differs, however. Distortions in relative payment between primary care services and other services have been addressed through the Medicare Fee Schedule. The Commission favors a uniform update for all physicians' services. If the Congress continues the surgical and nonsurgical distinction in the VPS, the Commission recommends a separate VPS for evaluation and management (EM) services. The Commission opposes establishing still another conversion factor for primary care.

Last spring, the Commission recommended that the differential update for 1993 (0.8 percent for nonsurgery, 3.1 percent for surgery) should apply to that year only and not affect payment in later years. This could be accomplished by using the 1993 conversion factor for nonsurgery ($31.25) as the base for the 1994 update for both nonsurgical and surgical services. Although this would not save as much as the President's proposal, the savings could be increased to that level by lowering the base for the 1994 update slightly from the $31.25 figure.

REDUCE PHYSICIAN MVPS AND UPDATE "DEFAULT" FORMULAS

This proposal would reduce the default performance standards for Fiscal Year 1994 and thereafter by increasing the size of the performance standard adjustment factor. In addition, the limits on reductions from the MEI in the default formula would be increased.

Changing the Performance Standard Defaults

As specified by OBRA89, the performance standard default formula is the product of four factors minus the performance standard adjustment factor. The performance standard adjustment factor is currently set at 2.0 percentage points. Under the proposed change, this factor would be increased to 3.5 percentage points for 1994, and 4.0 percentage points for all subsequent years.

The Commission supports changes to reduce this default formula in order to cut spending. As the Commission has developed its annual recommendations to the Congress on the VPS, it has consistently recommended a performance standard that is lower than the default standard in current law.

The specific adjustment factors proposed by the President are consistent with the Commission's practice of basing its recommendations on the principle of slowing the rate of growth of spending to the rate of growth of gross domestic product (GDP) by 1996 (after adjustment for the more rapid growth in the Medicare population). Our only suggestion is for the legislation to specify a long term projection in GDP as the default for the performance standard.

Changing the Update Defaults

Under the default formula, the update is determined by subtracting the difference between actual expenditure increases and the performance standard from the Medicare Economic Index (MEI). The amount that can be subtracted is limited to 2.5 percentage points for the update for 1994 and 3.0 percentage points for subsequent years. The proposal is to increase this limit to 5.0 percentage points for the update for 1996 and to 6.0 percentage points for subsequent years.

The Commission endorses the concept of increasing these limits, but recommends two modifications. First, a limit of 6.0 percentage points is too high. One of 5.0 percentage points would be preferable. Second, these limits should be symmetric. Given the large variation in year-to-year rates, it would be appropriate to have the same limits on amounts that can be added to the MEI. Thus, the Commission recommends 5.0 percentage point limits on additions or subtractions to the MEI effective with the update for 1996.

RESOURCE-BASED PRACTICE EXPENSE PHASE-IN

A very important component of the President's proposals that affect physician payment, from the perspective of both budget savings and policy, is the one to phase in resource-based practice expense (RBPE). Citing the Commission's work to develop a resource-based methodology for practice expense, the Administration proposes a transition to that policy of reducing practice-expense relative values for services in which the ratio to the physician work value is particularly high.

The Commission's methodology for RBPE involves estimating the direct and indirect costs for providing each service. Direct costs, which can be linked to the provision of specific services, are measured through industrial engineering methods. Indirect costs, such as office rent and salaries of nonclinical personnel, are allocated in proportion to the sum of direct costs and physician work. In its *1993 Annual Report to Congress*, the Commission recommends that a transition to RBPE begin in 1997. The delay reflects both the desire to complete the transition to the Medicare Fee Schedule before embarking on further restructuring of the pattern of payment and the time needed for collection of additional data on direct costs.

With a requirement for budget savings this year, the Commission had to consider whether to recommend obtaining a portion of that savings by targeting those services anticipated to be reduced under RBPE. Good arguments can be made for either making across-the-board cuts to obtain all of the savings or obtaining a portion of the savings in a way that changes the structure of payment toward the that envisioned for the future. The Commission recommends the latter.

We then considered whether the Administration's proposal is the best way to accomplish this. The proposal should be evaluated on two grounds: how closely the transition tracks the changes in relative payment under the RBPE methodology and how much additional payment restructuring and redistribution is appropriate. The Commission has simulated the Administration's proposal, comparing its payment rates for 1996 with those under current policy and those under the Commission's method for RBPE.

The Administration's proposal would cause significant reductions in payments for some services and specialties (Table 1). For example, services accounting for 12 percent of physician payments would have their payment rate reduced by 15 percent or more by 1996. Services accounting for 0.5 percent of payments would be reduced by 35 percent or more. Diagnostic services would bear the brunt of these reductions, with an 11 percent cut, with global surgical procedures cut 8 percent. At the specialty level, ophthalmology would experience a 10 percent reduction, with cardiology, thoracic surgery, and orthopedic surgery experiencing reductions of 5 percent.

When viewed as a transition to RBPE, the Administration's proposal would be uneven. To assess this, we calibrated the Commission's RBPE method to be budget neutral with the Administration's proposal. Diagnostic procedures would experience 32 percent of the eventual cut while global surgical procedures would experience only 18 percent of their ultimate cut (Table 2).[1]

At the level of individual services, a significant minority would have practice expense relative values reduced to a level below that under RBPE. Of the 300 office-based services covered by the Commission's pilot study of its RBPE method, 10 would be cut to levels below their RBPE levels.

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[1] Many diagnostic procedures are excluded from possible reduction in the Administration's proposal. For those not excluded, the percentage would be much higher.

The Commission also has concerns with the fact that this proposal would draw all of its payment reductions from the practice expense component of the relative value scale. The three components of the scale--physician work, practice expense, and malpractice expense--were calibrated to reflect data from physician surveys on shares of revenues from patient care. To draw large payment reductions from only one component would distort the relative weights of these three components. The result would be an underpayment of services for which resource-based practice expense is large in relation to physician work and an overpayment for services with relatively large physician work components.

We have developed an alternative to the Administration's proposal. First, only services provided in settings other than the office would be screened by comparing practice expense relative values with work relative values. For services in nonoffice settings, most practice expense is indirect costs. Under the RBPE method, indirect costs are allocated in proportion to direct costs and work. Thus, for these services, the Administration's proposal is very close to the Commission's method. For office services, many of which have substantial direct costs, physician work is not a good proxy for total practice expense. Thus, by limiting the proposal to nonoffice services, it is applied only to services for which it is appropriate.

Our preliminary simulations suggest that this modification would eliminate all of the cases in which practice expense relative values are reduced below projected levels under RBPE. The sharp reduction in payment for diagnostic services as a group would also be lower. Approximately 10 percent of the savings would be lost. These could be recovered by either a uniform adjustment in work values (this would partially address the issue of too much of the savings coming from the practice expense component) or an adjustment to the conversion factor.

For the second and third years in which this transition is in effect, we recommend that HCFA substitute screens based on the Commission's RBPE methodology. We understand that the micro-costing study by the Center for Health Policy Studies that covers 48 physician group practices will completed shortly. The results might well permit HCFA to develop screens based on projected RBPE values in time for January 1995 implementation. With such data, services in all settings could be screened for possible reductions in practice expense relative values.

Finally, we recommend that by 1997, this transition involving only payment reductions end and a transition to the full RBPE policy, which would involve payment increases as well as decreases, begin.

As the Commission has worked on methods to pay for practice expense, it has conducted parallel efforts to pay for malpractice expense. The 1993 Annual Report to Congress includes a recommendation to adopt a risk of service (ROS) method to pay for malpractice. RBPE and ROS share conceptual underpinnings and are also linked in the sense that specialties that have payments reduced under RBPE tend to have payment increases under ROS. The Commission has considered a parallel transition to ROS payment to reduce spending but has not had the time to develop a proposal. Nevertheless, it urges that if the Congress enacts a transition to resource-based practice expenses that it also enact ROS payment for malpractice expense.

DRG PAYMENT FOR INPATIENT SERVICES OF RAPs

The Administration has proposed to bundle payments for all of the inpatient services of radiologists, anesthesiologists, certified registered nurse anesthetists, and pathologists at a hospital into a single DRG-based payment. Payment would be based on the national average Medicare Fee Schedule payments for all beneficiaries admitted to hospitals for a specific DRG. If the hospital medical staff met certain qualifications to receive the payment, it could elect to do so. Otherwise, the payment would go to the hospitals.

When the Reagan Administration made a similar proposal in 1987, the Commission did not support it. Some of the problems with the earlier proposal have been solved. Nevertheless, the proposal would profoundly affect the complex relationships between hospitals and physicians and the Commission would want to devote considerable study to it before making a recommendation.

Instead, the Commission recommends a reform in payment for anesthesia care delivered by a team comprised of a certified registered nurse anesthetist (CRNA) and an anesthesiologist. Currently, Medicare pays 20-30 percent more for services delivered by a team than for those delivered by a solo anesthesiologist. Payments to anesthesia care teams should be capped at 120 percent of the payment to the solo anesthesiologist, declining 5 percentage points a year until reaching 100 percent. The payment to the team should be split so that each practitioner receives 50 percent.

The Commission also notes that radiology services have a slower transition to the Medicare Fee Schedule than is the case for physicians of other specialties. As an alternative to the DRG proposal, the Congress might consider a speedup of this transition to be more consistent with the standard transition.

ASSISTANTS-AT-SURGERY

The Administration's proposed budget reductions for assistants-at-surgery would require the Department of Health and Human Services (HHS) to identify certain procedures and types of patients that require a physician as an assistant-at-surgery. In all other instances in which an assistant-at-surgery bills Medicare, the primary surgeon's payment would be reduced by the amount paid to the assistant.

In recent years, payments to assistants-at-surgery have been reduced substantially. Under OBRA90, payments to assistants-at-surgery were reduced 20 percent, and procedures with physicians' billing as an assistant-at-surgery less than 5 percent of the time nationwide were excluded from payment. In addition, policies such as overvalued procedures and implementation of the Medicare Fee Schedule have reduced payments further by reducing payment rates for surgery that payment for assistants is tied to. From 1990 to 1991, this reduced Medicare's spending for assistants-at-surgery by almost half. In 1992, payments to assistants-at-surgery appear to have declined another 7.5 percent.

With payment for assistants already reduced by more than half, the Commission is reluctant to recommend further cuts without first assessing the impact of previous policies. The Commission plans to analyze data for 1992 over the next few months to assess the impact of these recent policies.

The Commission nevertheless encourages HHS, in consultation with the surgical specialty societies, to identify those procedures and types of patients which require a physician as an assistant-at-surgery. Such guidelines, even without restrictions on payment, might encourage more appropriate use of assistants by reducing some of the variation in practice style.

BANNING PHYSICIAN SELF-REFERRALS

The Commission has not done significant work on the issue of physician self-referral and thus cannot provide detailed advice on the Administration's proposal. We are aware of the recent research literature and its findings of large differences in rates of use between referral when the physician has no financial ties and self referral. Given the need for cost containment, legislation in this area is a priority, with application to private as well as governmental payers desirable.

ELECTRONIC BILLING INCENTIVE

This proposal would encourage more physicians to submit Part B claims electronically by charging a $1 penalty per paper claim. Recognizing that some physicians may need time to switch to electronic billing, the penalty would not go into effect until January 1996.

The Commission supports expanded use of electronic billing but has concerns with this approach. With the Medicare program having recently required physicians to submit all claims for Medicare patients, the $1 charge for paper claims appears to impose a significant "hassle" on some physicians that would produce only a limited gain for the program. Physicians most impacted by the charge would be solo practitioners with low volumes of Medicare patients who perform mostly low-priced services, such as visits.

Instead we suggest a number of steps to ease physician adoption of electronic billing. For example, the Congress could require use of a common electronic standard to be used by all insurers, including Medicare. This would reduce the fixed costs to physicians of adopting electronic billing.

CONCLUSION

I hope that these comments will be helpful to the Committee as it prepares to write legislation to meet the targets established by the budget resolution under tight time constraints. The Commission and its staff are prepared to work further with you in this process.

Mr. WAXMAN. Thank you very much, for your testimony. I was very interested in the Commission's recommendations for increasing the supply of primary care doctors. Would you tell us what percentage of first year residency positions are in primary care, and what kind of increase in the number of primary care positions the Commission would recommend to meet our needs.

Mr. EISENBERG. Right now, approximately 35 percent of the residency positions are in primary care specialties. Then, you have to add a caveat, which is that some of those individuals don't stay in general fields. Some of them might go into sub-specialties, for example, in internal medicine and in pediatrics.

The current data from the AAMC, the Association of American Medical College is really quite distressing, and suggests that less than 20 percent of 1992's graduating medical students say that they intend to remain generalists.

We believe that, as the Council on Graduate Medical Education does, that a target of about 50 percent seems to make sense. We have to confess, that there's not good data. But it is looking at international comparisons, looking at what HMO's tend to hire. The 50 percent number of generalists seems about right, and we would like to shoot for that.

We are concerned, that this is going to be a process that will take a long time to change, and we would like to start as soon as we can. But that target of 50 percent seems about right to the Commission.

Mr. WAXMAN. You testified that the Commission is reluctant to recommend further restrictions on payments for assistants at surgery. Is the Commission planning to develop any criteria concerning the circumstances under which an assistant at surgery is necessary?

Mr. EISENBERG. Our recommendation is that we turn to the specialty societies who are most involved in surgery, and ask the experts which surgical procedures they think an assistant is necessary. We could take that task on, if the Congress would like for us to take that task on. I would turn to Loren, and be sure that she agrees with me.

Speaking as a Commissioner, I think that the staff would enjoy doing that.

I think that would be an appropriate task for the Commission to take on.

Mr. WAXMAN. I understand that the Commission now takes the position that a separate and higher update to primary care services would not be desirable. Instead, you are recommending a single update. Could you give us some background on why the Commission believes separate targets and updates for surgical services and nonsurgical services is not a policy we should continue.

Mr. EISENBERG. The Commission has taken the position from the very beginning that we should have a single update, and that we should count on the resource based relative value system and its modifications to adjust the proper relative payment to different specialties.

We are not convinced that if we allow each subgroup of physicians or even yet geographic groups of physicians to have different conversion factors, that in the long term that will serve us well. We would, in the long term, end up with payment schemes where different physicians would have historically defined different fees that they would obtain for the same service, which is the system that we just tried to get away from.

Granted, it would be based on a little bit more logic than the previous system was, but we are still distressed about where that might take us. We would prefer to have a system whereby there is only one update. If there must be more than one update, then we would prefer that it not simply be surgical and non-surgical updates, but that there also be a separate update or E&M or evaluation and management services. Still, we would rather have a single update.

As an example to illustrate that, there is a substantial amount of change in technology and change in practice patterns that occurs between specialties for a particular service. During the past 10 years alone, a gallstone might have been handled by medical treatment with a drug called kenodioxide cholic acid. It might have been treated by a radiologist with lythotripsi or it might have been treated by a surgeon with traditional surgery and now with a new type of surgery, lapryscopic cholosystectomy.

We are concerned that as technology changes and that as practice ought to change, that if we have a different update and different volume performance standards for every different type of service, that we are going to lock ourselves into a static style of practice and not be able to respond to change in practice patterns.

That's one of a variety of reasons why we feel that way.

Mr. WAXMAN. Thank you, very much. Mr. McMillan.

Mr. MCMILLAN. Thank you, Mr. Chairman. Just basically with respect to primary care physicians—that seems to be a point of focus—are we trying to let the tail wag the dog, by promoting more primary care physicians at the education level? Or, is it a matter that has to be addressed at the compensation level, or are there other factors that are steering people into specialties as opposed to primary care.

I think this is a crucial question. I would like you to also address this. Under the concept of managed care as I understand it, and I think that's where the medical marketplace is moving on its own, what should we do to encourage that? Who are the gatekeepers in primary care? In other words, who makes the broad decisions with respect to standards of practice? Are they specialists or primary care physicians or are they both, and how are these roles going to shift in reform.

I am inclined to think the generalist probably is going to occupy a much bigger role if we do reform successfully than perhaps may have been the case in recent times.

Mr. EISENBERG. I couldn't agree with you more. What makes this issue so interesting is that it's so multi-factorial. There are so many issues that influence this. One of them certainly is the practice environment into which physicians will enter.

Pay is probably one of the issues, expected income. The style of practice and the organization of practice is certainly going to be a factor. If we do move toward more managed care arrangements, then we have to look at whether that will increase or decrease the attractiveness of practice to generalists. Will it mean that there are more hassles or fewer hassles for the physician who says I would like to be a personal physician, I would like to be a primary care physician.

I think in this regard, that is the regard to the kind of practice that the physician is looking at entering, I think what we have tried to do with in the past has been at least remedy the fee schedule in a way that it doesn't distract or detract from a physician's interest in going to primary care.

Certainly, one of the gatekeepers is the medical education system. We are trying to do everything that we can, and you will see in our report a number of proposals for ways in which we can improve the post-medical school education system; that is, the residency system, to encourage physicians to go into generalist or primary care fields. We need to change medical education as well.

It's difficult. The system will change very slowly. I will say anecdotally, I am one of two general internists who chairs a department of medicine. My other 120-odd colleagues are all sub-specialists, and that will change gradually. It will take a while. I think the more that the signals are there, that we want the educational system to change, the more that the field into which physicians will enter changes, the more we will see students entering primary care fields. It is very multi-factorial, and I know that some of the other people who will be speaking with you today will have views on that as well.

Mr. MCMILLAN. It's just my feeling from having thought through a lot of these processes and trying to work with the administration on things they are considering in health care reform, that some of the things we are going to do are going to engender abrupt change and probably should, and we are going to be timid about doing that.

I mean, I think this is one of those. Perhaps the generalists—maybe this isn't a perfect analogy—IBM, in trying to struggle with its management problems and lack of competitiveness—and it kept going back to people who only worked for IBM—their prescriptions were more of the same. Instead, they brought in somebody from a totally different field. He's essentially a generalist.

He may be able to see things and make decisions that those who are in the middle of it can't see and won't make. I think there's a lot to be said for that.

If I could go back to just one other thing, on the issue of—I think this gets maybe to another crucial point—on standards of practice and standards of reimbursement. I fear that we will try to micro manage the system. There are real pitfalls in that. I think we are already falling into those pits and have been.

Would you comment a little bit on your views on surgical fees, and let's say a comprehensive fee for the general procedure as opposed to compensating the respective participants in the procedure.

Mr. EISENBERG. The Commission has favored global surgical fees, and has worked with both the Congress and HCFA to try to determine some of the details about how a global surgical fee ought to be paid, how much before and how much after the procedure ought to be included.

We have started getting into the issues of the other participants in the process, for example, in looking at the assistants at surgery issue. We are concerned that there have been a tremendous number of changes in recent years in the way in which assistants at surgery are paid. As I alluded to earlier, we think we ought to probably stop and look at which kinds of assistants are necessary and how they ought to be paid.

I would point out though, as a personal aside, that paying one physician through another physician and expecting the surgeon to then pay the assistant at surgery and pay the consulting physician or pay the anesthesiologist, has a very profound potential effect on relationships among physicians and the nature of medical practice.

The Commission, as a group, hasn't been able to look at that question as you framed it, well enough to come back and say that we believe we should or shouldn't pay for all services through one individual or through one entity and pay all the other people who are trying to participate in that care.

Mr. McMILLAN. I would tend towards fixing that responsibility as simply as possible. Then, you shift the responsibility for cost control to the deliverer, it seems to me, as opposed to a bureaucratic approach to try to go back and review it. That, I think, has to be a crucial part of dealing with the issue of reform and cost.

Mr. EISENBERG. It sure does. There are at least two ways in which people are talking about dealing with that general concept. One is having a personal physician who is responsible for each patient, as that patient's case manager. That would put the primary care physician in the position that you are describing; that is, somebody who is representing the patient and being sure all his care is being coordinated.

The second way of dealing with that is to look at the organizations of care, as you alluded to at the outset, managed care organizations, and pay an organization of physicians a certain amount of money to take care of the patient and then let them worry about how they distribute those funds.

Both of those are pretty reasonable options, I think, that we ought to be looking at.

Mr. McMILLAN. Thank you, Mr. Chairman.

Mr. WAXMAN. Mr. Kreidler.

Mr. KREIDLER. Thank you, Mr. Chairman. Dr. Eisenberg, I am somewhat of a different kind of person here as a new member, in that for the last 20 years I have worked for Group Health Cooperative of Puget Sound in the State of Washington. I have worked in a staff model HMO during this period of time, and I have watched the internal battles that take place between specialty and primary, blood on the floor and everything else, as to how we distribute limited resources to make sure we meet the needs of patients and provide quality care and so forth.

It appears to me that getting away from all of these machinations of trying to use Medicare and Medicaid reimbursement seems to really point toward getting to a system that uses some form of integrated capitation system, meaning vertical integration from primary to specialty to hospital and so forth.

It seems like it offers tremendous value over the current system, number one. Number two, it does allow so to speak market forces to more appropriately act in dictating reimbursement, whether it be some form of a capitation group reimbursement to a primary care group, a radiology group, a hospital, or whether it be to a total integrated plan, it makes an awful lot more sense than trying to do what we are doing.

Do you have a comment on that?

Mr. EISENBERG. In the report that comes to you today, you will see that there are a couple of chapters that talk about the way in which health care reform might be conceived in the context of some of the issues that we talk about regarding the reform of fee for service system.

We deal with just the issues that you describe. There are clearly some advantages of the model that Group Health of Puget Sound represents. Certainly, that's one of the stars. It's one of the examples of a system that seems to work. We are concerned that there are some other examples where it doesn't work quite well, and we want to figure out what the difference is and try to design a system as you do, that takes advantage of the winners.

I think that the blood that's on the floor in—was on the floor—in Seattle, is probably a predictive of the kinds of debates and arguments that will occur within groups of physicians as they try to decide how they are going to divide up that capitated pie.

One of the contributions that we think we have made in the PPRC and that the Congress has made, is trying to develop some database guidelines for ways in which resources might be divided up among physicians. What we are finding, I think, is that more and more group practices and more and more HMO's are looking at the resource based relative value scale in some of the issues that we are dealing with in practice costs, as a way of dividing up the pie in a way that there's less blood on the floor and most of the discussion occurs above the neck rather than below the neck.

I have seen that myself in institutions where I have been. As people say this specialty is getting too much and this specialty is getting too little, everybody says why don't we just leave it out of our debate and look at what the Congress has decided to do with the Medicare fee schedule. Maybe that's a pretty reasonable model to use.

I would maintain that whether the current system of paying physicians through Medicare is maintained or not, that a lot of the progress that you have made over the past few years is going to provide some lessons to those group practices and capitated systems that will be very helpful.

Mr. KREIDLER. The bottom line is, it would be far preferable to do it that way instead of having Congress or HCFA—whoever it will be—to try to arrange different types of reimbursement outside of the——

Mr. EISENBERG. The Commission isn't going to take a position and hasn't taken a position, on what the future health care system should look like. We are, like everybody else, looking forward to seeing what the task force recommends and then look forward to working with you to respond to that proposal.

That's probably as much as I should say right now about whether or not moving towards managed care or maintaining two parallel systems or sticking with fee for service system is going to be better.

Mr. KREIDLER. Thank you, very much. Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you, Mr. Kreidler. Mr. Slattery.

Mr. SLATTERY. Thank you, Mr. Chairman. Dr. Eisenberg, in you judgment, how long is it really going to take realistically, for us to correct this imbalance among our providers in terms of the primary care doctors and the specialists; whether it's 20 or 30 percent that are primary care doctors versus 70 or 80 percent that are specialists, whatever number you use. There is a great imbalance, and most people, certainly those advocates of managed competition, acknowledge that there's going to be a desperate need for primary care doctors to make this whole concept work.

I guess my question is, what are we looking at? Are we looking at a 5 year, 10 year period of time? How long is it really going to take to complete this transition, in your judgment.

Mr. EISENBERG. There is a study that is going to be coming out that has been done by David Kindig who is at the University of Wisconsin, collaborating with people at the Bureau of Health Professions, Mark Revo and Fitz Mullens, specifically, in which he does a projection to answer your question. Here's what he says.

He says if we could get every single medical student to go into generalist careers then looking at the physicians who will be retiring who have a higher proportion unfortunately of generalists than do younger physicians, that it would be at least 20 years before we got to the target of 50 percent. If we had 50 percent of physicians who are graduating going into generalist careers over the next number of years then they have plotted out to see at what year would we get to 50 percent of the total physicians that would be generalists, and they have concluded it would be somewhere around the year of 2040.

Mr. SLATTERY. What was that last part, again?

Mr. EISENBERG. It was 2040. They have looked at the total number of physicians who would be in the population. What their distribution would be of generalists and specialists, taking into consideration the retirement of physicians who are current generalists and specialists and assuming that 50 percent of physicians coming into the workforce would be generalists, given that they said what year would we get to the target.

Mr. SLATTERY. That's 2040. The other one is, all of the doctors coming in were general practitioners, and it would still be about 20 years.

Mr. EISENBERG. Exactly. Many of us feel——

Mr. SLATTERY. Does that assume a dramatic change in compensation for the primary care doctors versus the specialists also? I mean, what assumptions are we working with?

Mr. EISENBERG. It makes no assumptions, except that somehow we are going to get these guys to stay in generalist practice.

Mr. SLATTERY. When you cut through the fog, isn't the bottom line money?

Mr. EISENBERG. Not entirely money.

Mr. SLATTERY. It's about 80 percent money, isn't it?

Mr. EISENBERG. Pardon?

Mr. SLATTERY. Isn't it about 80 percent money? When you make $200, $300, $400,000 a year as a specialist doing something versus being a general practitioner in an underserved area making maybe $85,000 or $90,000 if you are lucky. It's not a mystery as to why people would choose to be specialists, I don't think.

If we don't correct the pay, can we ever hope to get people into the primary care area?

Mr. EISENBERG. I think you are right. I think the answer to that is no, we wouldn't. But the flip side of the question though that you would ask after we solve that question is, now we have the pay straight and are people going into generalist fields. Were there other barriers, other than just pay.

There are other barriers. The educational system is a relative barrier. The perceived hassles of practice are a relative barrier, and then there are others. I wouldn't put all of my eggs in a monetary basket. I do think it probably ranks right up there in first place.

Mr. SLATTERY. If we are looking at a 20 year transition period optimistically, a 50 year transition period realistically, we have a big problem to make this whole transition work.

Mr. EISENBERG. We do.

Mr. SLATTERY. That tells me then, we have to look at fundamentally changing what doctors are doing at the primary care level, and who is providing that service there. That's the only other option. I mean, you really have to get into the question then of alternative providers and what nurses are doing and what physician assistants are doing. Isn't that the only logical response to that?

Mr. EISENBERG. There is one other. That is certainly a logical response, that we need to look at nurses and physician assistants, but the same problem exists there. We are not—we need to train more people to do primary care. Whether you believe it ought to be physician assistant, nurse practitioner or a physician, the pipeline is a long pipeline. It's going to be tough to get up to the numbers we need, no matter which discipline does it.

The other strategy that many have discussed and the Commission has discussed in part is this question. If we currently have a lot of physicians—and we currently are about in the middle in terms of the number of physicians per 100,000 among the OECD countries—we probably have enough doctors. It's just that they are not in the right disciplines.

Another approach is to say we have this huge workforce out there. Instead of having them go into other fields like non-medical fields, maybe we could take that group and retrain them or redirect them towards doing more primary care. Many of them are internists, who were at one time trained to be generalists. The question is, have they retained those skills. If they have, let's give them some encouragement to do generalist practice. If they haven't, let's see if we can develop some programs to re-tool them and perhaps even other physicians, to provide high quality primary care.

If we do that, then maybe we could accelerate the process.

Mr. SLATTERY. I know that my time has expired. Give me a specific example of a couple of things that we can do to encourage, entice, coerce, providers to move into primary care in the short term, short of money.

Mr. EISENBERG. In addition to money. I think dealing with the issues that Mr. Toby dealt with regarding the hassles of practice is one. For example, to deal with—I think you were the one who asked the question about electronic billing.

Our analysis of that suggests that about one-half of the bills are being submitted electronically now. Who is not submitting the bills electronically, it's the small practice, it's the rural practice. Is that really the guy we want to add a $1 hassle to?

Our concern is that we look down that list of things that physicians say are just annoying. When they get a medical student in their office, they say that I don't know that you really ought to go into my field. Maybe you ought to pick something else to get into. Let's eliminate those, and then I think maybe we could get some more students going and more residents going into generalist fields.

We probably could do a better job if we understood more about the educational system and helped to shape the educational system to move in that direction. Quite frankly, the issues that were raised earlier about the patient's perceptions in the system need to be remedied. If we have a system whereby every patient has a case manager, that is, a generalist physician or primary care physician responsible for them and there is some channeling of patients to specialists, I suspect that physicians might see that as a relatively attractive job opportunity, if there aren't too many hassles in it.

I think we could go down a long list, as can the family physicians and internists who will be speaking with you——

Mr. SLATTERY. What is the——

Mr. WAXMAN. Mr. Slattery, we are really going to have move on. You have one last question.

Mr. SLATTERY. No.

Mr. WAXMAN. Thank you very much, Dr. Eisenberg, for your testimony. I would like to now call forward, four witnesses to testify together. Dr. Jerald Schenken, member of the Board of Trustees, American Medical Association; Dr. K.K. Wallace, chairman of the Board of Chancellors, American College of Radiology; Dr. Paul Ebert, director, American College of Surgeons; Dr. Robert Graham, executive vice president, American Academy of Family Physicians.

This panel includes a broad spectrum of organizations, representing physicians in practice. We want to thank you for being with us today. We are looking forward to hearing your reactions to the task before us.

Let me also indicate, your statements will all be in the record, and to limit your oral presentations to 5 minutes. Dr. Schenken, why don't we start with you.

STATEMENTS OF JERALD R. SCHENKEN, MEMBER, BOARD OF TRUSTEES, AMERICAN MEDICAL ASSOCIATION; PAUL A. EBERT, DIRECTOR, AMERICAN COLLEGE OF SURGEONS; K.K. WALLACE, CHAIRMAN, BOARD OF CHANCELLORS, AMERICAN COLLEGE OF RADIOLOGY; AND ROBERT GRAHAM, EXECUTIVE VICE PRESIDENT, AMERICAN ACADEMY OF FAMILY PHYSICIANS

Mr. SCHENKEN. Thank you, Mr. Chairman. My name is Jerald Schenken. I am a practicing pathologist from Omaha, Nebr. A starting point, we all must recognize that Medicare and Medicaid cuts cannot be viewed in a vacuum. With momentous changes in how health care services are provided and covered fast approaching, the AMA is not treating Medicare and Medicaid budget cuts and the reconciliation process as business as usual.

The AMA and physicians are cognizant of the need to reduce the budget deficit and to control spending, and we recognize that such decisions are never easy. We suggest that you consider the following principles. Avoid micro management, use reconciliation to set directions for reasoned program improvements, maintain the integrity of Medicare new physician payment system, refrain from actions that could increase the regulatory burden, and use caution in program expansion as new benefits invariably cost more than are projected.

From this framework, the AMA has reviewed the President's recommendations, and it should come as no surprise that the AMA does not support all of the proposed initiatives. However, we take very seriously, the challenge to find potential program modifications that will achieve the required level of savings.

While all of the actions we are recommending in our detailed statement have yet to be scored, we estimate that taking these actions would result in savings of over $7.5 billion in the next fiscal year and approximately $31 billion over the next 4 fiscal years. Should estimates by others differ our staff would appreciate the opportunity to work with you, to examine the facts and assumptions and reconcile those differences.

Mr. Chairman, as you know, this exercise is not new to the AMA and the others who are before the committee today. What is new, however, is our message and commitment to you, that we want to be viewed and accepted as part of the solution. To a certainty, we will continue to oppose those proposals that will harm our patients or that will splinter the medical profession, proposals such as RAP, DRG roll in, the establishment of Medicaid drug formularies, the evisceration of RBRVS through arbitrary reductions of practice component and modification of the default formula, and setting of a single fee for surgical services regardless of the value provided by the assistant surgeon, are clear examples of where medicine is united in our opposition to the President's proposals.

Our reasons and supporting arguments can and will be made available to your committee, and our former and current written statements.

We also recognize our responsibility to aid you in taking actions that will produce the needed savings from, or the revenue for, the Medicare and Medicaid programs. This is what we mean by telling you and the Nation that our desire for a new partnership is present.

In the spirit of shared sacrifice the AMA supports actions to achieve dollar savings from physicians' provided services from the amount paid from clinical laboratory testing, and from limits on the unethical practice of self-referral. In addition, and to give you an alternative to proposals such as the RAP/DRG's, single surgical payment and the practice component reduction, we have discussed the possibility of suggesting a 6 month delay in all part B updates rather than a series of disruptive cuts proposed by the administration.

Such a delay would provide significant 1994 savings and not disrupt the achievements of the RBRVS and physician payment reform. However, Mr. Chairman, there are potential serious consequences in making this suggestion in light of its impact on many rural and intercity areas and for some practitioners who are on the margin of making a go of their practices. These must be addressed, before this should be considered further.

Nevertheless, we estimate that delaying the payment update will result in an additional $2.1 billion savings in the fiscal year of 1994. This is a real and readily achievable savings, and does not come at the expense of more Medicare micro management or at the expense of our patients. We would be pleased to work with you, to see what accommodations can be achieved.

In conclusion, we cannot lose sight of the fact that the Medicare and Medicaid program provide a vital health and medical service to more than 60 million Americans. Because of this reality, we stand firm in saying that substantive changes in the operation of these programs should be made within the context of the needs of the beneficiaries, not put together just to meet a budget target.

Thank you, Mr. Chairman. As time allows, I will be pleased to respond to the committee's questions.

[Testimony resumes on p. 84.]

[The prepared statement of Dr. Schenken follows:]

STATEMENT

of the

AMERICAN MEDICAL ASSOCIATION

to the

Subcommittee on Health and the Environment
Committee on Energy and Commerce
U.S. House of Representatives

Re: Medicare and Medicaid - FY 1994 Budget Proposals

Presented by: Jerald R. Schenken, MD

March 31, 1993

Mr. Chair and Members of the Committee:

My name is Jerald R. Schenken, MD. I am a practicing pathologist from Omaha, Nebraska, and a member of the Board of Trustees of the American Medical Association. With me is Bruce Blehart from the Association's Division of Federal Legislation. The AMA appreciates this opportunity to appear today to discuss the subject of Medicare and Medicaid Budget proposals for FY 1994.

As a starting point, we all must recognize that yet another round of Medicare and Medicaid program cuts cannot be viewed in a vacuum. Your actions this year will be part of a profound series of changes that will alter forever how health and medical care are received in America. As you know, Mr. Chairman, the AMA is proud to be able to say that physicians are leaders in calling for major reform of our health care system. The status quo that has allowed so many of our citizens and patients to have inadequate or even no coverage for health and medical care simply is unacceptable. We recognize the need for universal coverage and that attaining this essential goal will not be easy. We support changes that will end discriminatory underwriting in health insurance so that small businesses can afford coverage. We support portability of coverage and real competition in the health benefits market.

We believe a partnership can be forged between the medical profession and the government to assure quality of care and budget predictability in a setting of fair negotiations. We support outcomes assessment research and the use of practice parameters to assure the value of medical care.

This is our starting point, and we are pleased to see that movement in this direction is coming and coming soon. With these momentous changes in the offing and with the real desire to effect positive change in the health care delivery system for all Americans, we urge caution in treating Medicare and Medicaid budget cuts and the reconciliation process as ''business-as-usual.'' While we accept that government programs, including Medicare and Medicaid, must be subjected to cuts in the name of deficit reduction and government belt tightening, it must be recognized that changes made in the government's primary health care programs will send a clear signal as to how physicians, beneficiaries and others can expect to be treated by the federal government in a reformed health care system. Modifications that create further or increased hassles or even appear to be unfair will only make it more difficult to effectuate the kind of change we want for the entire health care system.

Whatever changes are visited upon the Medicare and Medicaid programs through this year's impending budget reconciliation process should have the dual purpose of savings and program improvement. Unfortunately, the blueprint from the past illustrates the difficulty in attaining this goal. The President's recently released series of proposed substantive program modifications is designed to achieve savings. We are concerned that this follows a pattern of huge Medicare reconciliation packages that have involved literally hundreds of substantive changes over the last decade. These budget driven changes have created substantial turmoil and confusion and the Medicare law is one of the most complex statutes in existence with thousands of pages of seemingly constantly changing instructions and interpretations.

Budget based proposals, such as the Medicare denial of payment for interpretation of most EKGs and arbitrary reductions in physician payments during the first four years of their billing the Medicare program, represent arbitrary actions of highly questionable merit even in terms of potential savings. These provisions did not make good operational sense and, last year, both Houses of Congress voted to repeal them in a budget neutral manner. For this corrective action, we thank the Chairman and this Committee for supporting the necessary legislation. However, this corrective legislation was vetoed for unrelated purposes, and again we are asking for your support to reverse these past legislative actions.

The American Medical Association is cognizant of the need to reduce the budget deficit and to control spending appropriately. Such decisions are never easy. However, the way in which Medicare program cuts are achieved is very important to program operations and the impact on program beneficiaries. With this Committee now facing a reconciliation target of savings that must be achieved, we suggest that you consider the following principles concerning the Medicare and Medicaid programs.

o Micro-management of Medicare is not an effective way to obtain budget savings. Such program changes disrupt the delivery of services and continue the administrative turmoil that has shadowed the program for more than a decade. For example, we do not believe that the proposal to make a single payment for inpatient radiology, anesthesia and pathology services, as the Administration proposes, should not be adopted. Providing no savings in 1994, the proposal would substantially disrupt the existing relationships between hospitals, patients and this select group of physicians.

- The reconciliation process is not the place to determine, through arbitrary reductions in Medicare payments for direct medical education costs, how to solve physician workforce issues or how to encourage more physicians to train in the primary care fields. Such decisions should be made within the context of a comprehensive overview of the medical education process, not as a budget fix.

- Maintain the integrity of Medicare's new Physician Payment System that is based on a Resource Based Relative Value Schedule (RBRVS). In its second year of a five year transition, it is important to achieve the goals of a sound method of determining physician reimbursement and to encourage the delivery of needed care. Changes that break down the relationship between input and resource costs and reimbursement for services will undo a major accomplishment of establishing a rational basis for determining Medicare reimbursement. This Committee has long been a supporter of the RBRVS. The AMA was also a leader in calling for the development of an RBRVS and worked closely with various Members in seeing the RBRVS go from idea to completion. While we continue to have problems with some features of the new payment system, we still support this methodology.

- Avoid increased program costs by refraining from enactment of increased regulatory burdens. Implementation of the Clinical Laboratory Improvement Amendments of 1988, the OSHA Bloodborne Pathogen Standard, and the Americans with Disabilities Act in just one year have added significantly to the costs of providing medical care. Compliance with CLIA-88 alone is costing individual physicians thousands of dollars per year.

- Program benefits should not be expanded at the same time you are trying to find major savings. New benefits invariably cost more than projected.

- Comprehensive health system reform should serve as a vehicle for evaluating the role of Medicare in a competitive environment as well as the place for a comprehensive review of physician workforce issues including the best ways of addressing physician specialty issues.

From this framework, the AMA has reviewed the President's recommendations. It should come as no surprise that the AMA will not support all of the President's initiatives. However, we take very seriously the challenge to find potential program modifications that will achieve the desired level of savings. In addition to considering the Administration's budget proposals, we also suggest that the Committee look to items that had been proposed by previous Administrations and others that would reduce costs without disrupting care. For example, bringing state and local government workers hired before April, 1986, into the Medicare program would raise $1.2 billion in first year revenues alone. Because most of these workers usually wind up receiving Medicare coverage through a spouse or non-governmental employment, it only makes sense that they pay their fair share during their full working careers.

The following sets out our position on the President's Medicare and Medicaid budget proposals. While all of the actions we are recommending have yet to be "scored," we estimate that taking these actions would result in savings of over $7.5 billion in the next fiscal year and over $30.00 billion over the next four fiscal year period.

MEDICARE PART B

Reduce Physician Fees in 1994 Except Primary Care - This proposal would give the full payment schedule update for primary care services. The update would be reduced by about two percentage points for all other care.

The AMA does not support this proposal. Since 1984, the update for physician services has been substantially reduced by budget driven reconciliation action. Another round of reductions, especially a reduction that differentiates between services, will not be easily accepted by the medical community. While we agree with the intent behind the proposed differential, making primary care a more attractive career path for physicians, we do not believe the annual RBRVS payment adjustment is the best means for effecting such policy. Differential updates undermine resource-cost basis of the payment schedule. There are considerably more direct means available for fostering primary care. The AMA maintains that RBRVS updates should be consistent and across the board.

To address the Committee's need to find Medicare/Medicaid savings in a manner that avoids further micro-management, is consistent with our principles, and provides a simple and viable alternative to proposals such as the RAP DRG roll-in, single surgical payment, and the practice component reduction, we have discussed the possibility of suggesting a six month delay in all Part B updates rather than the series of disruptive cuts proposed by the Administration.

Such a delay would provide significant 1994 savings of about $2.1 billion and not disrupt the achievements of the RBRVS in physician payment reform. However, there are consequences in making this suggestion in light of its impact in many rural and inner-city areas and for some practitioners who are on the margin of making a go of their practices. Nevertheless, a straight forward six month delay in all Part B updates would be far preferable to the series of highly disruptive cuts proposed by the Administration. Such a delay would provide significant savings. It would not disrupt the achievements of the RBRVS in physician payment reform, and it would not come at the expense of our patients or more Medicare micro-management. To address the possibility of protecting those providing rural or inner-city care or others where the six month delay would create extensive problems, we would be pleased to work with you to see what accommodations can be achieved.

> Resource-based Practice Expenses Phase-in - This proposal would phase-in a resource-based system for practice expenses under the physician payment schedule beginning in 1997 (a 1993 PPRC suggestion). As an interim step to this phase-in, practice expense RVUs would be reduced in 1994, 1995 and 1996.

The AMA does not support this major reduction in the RBRVS. Rebasing practice expenses in this manner, especially during the initial RBRVS phase-in period, would be highly disruptive. While there are anomalies in the practice expense component that need to be addressed, moving to a resource based methodology can be achieved without again extracting huge sums out of the Medicare program. Our concern is that the proposed process to reset the payments for practice expenses would be contrary to the RBRVS by skewing distribution for budget purposes as opposed to setting payments based on accurate data.

We believe that legislation should be enacted to give HCFA the authority to correct anamolies in the current practice expense values. For example, pericardectomy performed with a bypass currently pays $250 less than the same procedure without a bypass. HCFA does not believe that it has the authority to correct such situations. We also agree with the PPRC that HCFA should be directed to collect data on physicians' actual practice expenses. HCFA should use these data to develop a resource-based practice cost methodology that would better reflect these actual costs, and HCFA should report to the Congress by 1996 on a methodology that could be implemented beginning in 1997 (after complete phase-in of the RBRVS).

> Reduce Physician MVPS and Update "Default" Formulas - This proposal would refine the method by which Medicare increases payments to physicians. The proposal would reduce the default formula. The projection for the potential rate of growth also would be lowered.

The AMA, does not support setting the assumption for Medicare growth on the rate of growth in the gross domestic product (GDP). Historically, the growth in costs for providing health and medical care has exceeded the GDP, and there is no basis to assume that the Medicare program that provides coverage for the majority of care received by the elderly and disabled populations (those with the greatest need for health and medical care), especially outside of major health system reform, can have its rate of growth slowed to the rate of growth in the GDP.

> Bundle Inpatient Radiology, Anesthesia and Pathology (RAP) Payments - Medicare payments for inpatient radiology, anesthesia and pathology would be bundled into a fixed payment per discharge. Payment would be made either to the hospital or the medical staff, and beneficiary coinsurance would be set at 20% of the bundled amount. The proposal states that this approach would give physicians and hospitals incentives to be cost-conscious, provide only medically necessary services and eliminate the provision of marginal services.

Every time this proposal has surfaced, the AMA has opposed it. The past reasons for opposition are still true, and we continue to oppose this concept. The DRG payment concept for these services would limit physician patient relationships, and would set an inappropriate precedent for bundling physicians' services. The so-called RAP services generally are provided at the request of an ordering physician. While marginal services need to be eliminated, it is very difficult to see how this would occur for the services of an anesthesiologist for a patient undergoing surgery, the services of a pathologist who conducts and interprets a laboratory test, or the services of a radiologist in responding to a STAT request for X-ray or other services.

Even if instances could be identified where this care could accurately be described as marginal, savings would be unlikely as the waiver of liability provision probably would apply. Also, this is an example of micro-management that would be contrary to directions taken when the RBRVS was instituted.

> Single Fee for Surgery - This proposal would not allow Medicare payment above the level allowed for the primary surgeon for the services of an assistant at surgery. While exceptions would be allowed for "particularly difficult cases," Medicare payments to the primary surgeon would be reduced by the amount of any payments for an assistant at surgery.

The AMA does not support this proposal. It would come on the heels of just implemented 1990 legislation that already severely limits the use of and payment for assistants at surgery, and it simply is contrary to optimal patient care needs. Also, many hospital medical staff bylaws require the use of assistants at surgery as a means of optimizing patient care during particularly hazardous moments in the provision of care, and it is questionable why such a patient care standard should be limited.

> Part B Premium at 1995 Percentage of Program Costs with a Limit of 27% of Program Costs - The Part B Premium is set by law at 25% of program costs. As the budget proposals would lower program costs, the premium should also come down. This proposal would still decrease the dollar amount of the premium while raising funds by setting the premium for 1996 and 1997 at 27%.

Recognizing that the proposal would not result in individuals paying a higher premium in dollar terms, the AMA supports this action that is consistent with the fact that the premium was supposed to cover 50% of program costs when Medicare was instituted. The AMA also believes that consideration and support should be given to a proposal put forth in the previous Administration calling for an increase in the premium rate for individuals with annual income of more than $100,000 and for couples with annual income of more than $125,000. This reasonable means testing proposal, as recommended in 1991, was slated to accrue $313 million in annual revenue, or approximately $1.25 billion over four years.

> Increase Hospital Outpatient Cut - This proposal would extend the current cost reduction of setting these payments at 94.2% of costs to 90% of costs, beginning with services rendered during FY 1996 and thereafter.

While the Association previously has opposed such cuts, we recognize that the still growing volume of services provided in hospital outpatient departments has the potential to offset the proposal. Also, with all elements of the health care spectrum being asked to contribute to the need to lower spending, this seems a reasonable action to maintain the playing field between those who provide care and to address the substantial growth in costs associated with hospital outpatient departments.

Reduce Payment for Clinical Laboratory Services and Provide No Update to Laboratory Payments through 1998 - The laboratory payment schedule currently is set at 88% of the national median, and it would be reduced to 76%. In addition, no annual update in these payment amounts would be allowed through 1998.

The AMA recommends partial support for the President's proposal, by modifying it so that the payment cap would not be lowered below 80% of the national median. While we would prefer not to see lower payment amounts for these services, it is noted that setting the payment cap based on a median will result in payment for many of these services not being affected. Also, the lower payment amount might have the desirable effect of lowering the volume of questionable laboratory services.

Physician Ownership/Referral - This would extend ownership/referral prohibitions applied for clinical laboratory services to services such as: physical and occupational therapy; radiology and other diagnostics; radiation therapy; durable medical equipment, and parenteral/enteral nutrition equipment and supplies.

The AMA supports this proposal if it is drafted in a manner that is consistent with exceptions for community need as specified in the related report by our Council on Ethical and Judicial Affairs. Where physician investment is the springboard for allowing patient access to previously unavailable care or improved care that will benefit those patients, care must be taken to assure that a blanket prohibition does not jeopardize that care. We hope to work with the Chairman and the Committee in addressing issues such as patient access exceptions, shared laboratories, the divestiture period, and clarifications for group practice situations.

> Electronic Billing Incentive - This proposal would create an incentive to encourage submission of Medicare Part B claims via electronic formats by charging $1 per paper claim beginning January 1, 1996.

The AMA does not support this proposal. While we know that there are positive benefits of moving to electronic billing and taking advantage of other computerization benefits, this should not be achieved through disincentives. Where the proposed penalty would be applied, it is likely to hit hardest those who provide a small volume of Medicare covered primary care services that already are provided at a low fee level. With the development of a uniform claims format and software down the road, it is likely that more and more physicians and others will move to electronic billing, and the proposed savings still will be realized without the penalty being applied.

> Durable Medical Equipment (DME) Proposals - DME payments would be reduced by: "tightening" the national payment limits; reclassifying certain items; restoring the carriers ability to adjust payments where

the amount is grossly excessive or deficient based on price information; and give carriers flexibility to require demonstration of medical need in advance of delivery of the DME to the patient. The payment schedule for orthotics and prosthetics would be changed to the DME payment schedule. A payment schedule would be established for parental and enteral nutrients and supplies, with parenteral and enteral equipment paid on the same basis as DME.

The AMA recommends support for this provision as a reasonable action to address costs associated with the provision of DME.

Set EPO at Non-US Market Rates ($10 per 1,000) Units -The proposed payment reduction of $1 per 1,000 units would reduce the disparity between Medicare's current reimbursement rate and the actual cost that facilities pay for EPO based on recent findings of the HHS IG.

The AMA recommends having the government purchase the EPO directly from the manufacturer when the intended use is to facilitate treatment of patients with ESRD. Anecdotes from physicians who provide ESRD services tell of situations where the provision of EPO is inadequately reimbursed in some instances. Without limiting the availability of EPO, we believe that possibly an even greater savings can be achieved with an end to hassles facing those physicians treating patients with ESRD by having the government purchase the EPO directly from the manufacturer and in turn supplying the drug to physicians and others.

Extend IRS/SSA/Data Match - This proposal, aimed at enhancing determinations of Medicare secondary payor status, would extend the authorization of the data match through 1998.

Extended Provision Requiring Secondary Payment for Certain Disabled Beneficiaries - This proposal would make permanent the authority setting Medicare as the secondary payor in situations where potentially eligible disabled individuals have other employer based group health care coverage. The current authority is set to end at the end of FY 1995.

Extended Provision Requiring Secondary Payment for Certain Beneficiaries with End Stage Renal Disease (ESRD) - This proposal would make permanent the authority setting Medicare as the secondary payor in situations where potentially eligible individuals receiving ESRD services have other employer based group health care coverage. Secondary status pertains for an 18 month period. The current authority is set to end at the end of FY 1995.

Medicare Secondary Payor Reforms - This proposal would make all of the employer thresholds for determining secondary payor status consistent with the aged provisions (employers of 20 or more). This would lower the disabled eligibility threshold from employers of 100 or more and set a threshold for ESRD patients.

The AMA historically has supported Medicare being a secondary payor where other coverage is available, and we recommend support for these four proposals.

MEDICARE PART A

Phase in a Reduction in the Indirect Medical Education (IME) Payment Adjustment Ratio - This proposal would alter the IME adjustment formula to reduce these payment amounts beginning in FY 1996.

The AMA recommends support for reducing the IME adjustment to 7%, as also called for by PROPAC, and for a study on how to best finance graduate medical education (GME) to go forward. The AMA historically has supported the IME adjustment as a means of recognizing the added costs incurred by teaching institutions for teaching and as a proxy for uncompensated care. Where initial IME payment amounts were set at a level considerably higher than the added costs of medical education, we have supported reductions to an amount that is adequate to meet the actual, education associated costs that are incurred. To determine the real value and the appropriate IME payment amount, we support conducting a study conducted that will involve physicians, the public, the institutions and others with a stake in GME.

Reform Payments for the Direct Medical Education (DME) Costs - This proposal would base payments on a national average per resident amount, with greater weight for primary care.

The AMA supports action to establish uniform accounting for these services, especially in light of the wide variation of cost per resident reported among institutions. With the mean cost for resident services at approximately $51,000, the reported variation between $7,500 and $187,000 must be addressed. By moving to uniform accounting, it is certain that some savings would result. The AMA opposes using a national average in setting the DME payment, as this will underpay in many inner-city areas and overpay in other situations. Also, using a national average overlooks the fact that residency training costs necessarily must vary by specialty and to account for other factors. Again, we recognize the need for this issue to be subject to scrutiny as the manner in which our nation finances GME is examined.

> Eliminate Add-on for Hospital-based Home Health Agencies (HHAs) - This proposal would eliminate the differential, subjecting hospital-based HHAs to the same cost limits as freestanding HHAs.

The AMA questions the wisdom of continuing to pay hospitals more for the provision of HHA services, and we support this proposal.

> Eliminate Return on Equity Payments for Proprietary Skilled Nursing Facilities - This proposal would eliminate Medicare ROE payments to proprietary SNFs, to create "fair competition" between SNFs.

The AMA has no position on this proposal.

> Extend the 10% Reduction in Hospital Capital Payments - Under current law, hospital capital payments (inpatient Part A and outpatient Part B) are reduced through FY 1995 by 10%. This proposal, consistent with a recent HHS IG report, would make the reduction permanent.

The AMA supports this provision. We note that capital costs have been reduced in this manner pending conversion of capital payments into the prospective payment system as an add on. If this proposal is not adopted, there would be a 10% increase in payment for hospital capital costs.

Hospital Update at Market Basket Minus 1% in FYs 1994 and 1995 - This proposal would set a hospital update amount below the market basket used to set this annual increase.

The AMA historically has called for the hospital update to be made at least at the full market basket amount, and we oppose this proposal. With many hospitals reporting net operating losses, it is particularly difficult to support an update below the market basket amount.

Move the Annual Changes in the PPS Updates to January 1 of Each Year - This proposal would move the PPS update from October 1 to the following January 1.

Recognizing the need to achieve savings, the AMA supports this provision. If a higher level of savings are needed, the AMA also would support a one-time delay in this update to July 1, 1994, with future Part A updates occurring on January 1 thereafter.

MEDICAID

Remove Prohibition on Medicaid Drug Formularies - States now must provide drug coverage for all drugs where they are listed in the medical literature and where the manufacturers have signed rebate agreements. This provision would allow states more flexibility in setting drug coverage.

The AMA continues to oppose arbitrary and budget driven drug formularies as they could be overly restrictive. By eliminating the medical literature requirement, the proposal clearly will limit drug availability, and this will occur to the detriment of patients.

> Personal Care Services - This proposal corrects a so-called "drafting error" that would have placed a new mandate as of 1995 on state programs. As proposed, states would maintain the option of paying for personal care services provided outside of a beneficiary's home.

The AMA has no position on this proposal.

> Reduce Medicaid Administrative Match to 50% - This proposal would match all administrative costs at 50%.

The AMA recommends that where federal Medicaid law has imposed administrative duties on the states, the initial matching payment should be set at a higher level. However, the administrative match should be phased down to a lower level as higher start-up costs are accrued. States should be allowed the option of petitioning for maintaining higher administrative matches where reductions are considered.

> Tighten Estate Recoveries/Transfer of Assets - This proposal would close unspecified loopholes and ensure that those with substantial personal assets pay a fair share for nursing home care and other medical services before Medicaid starts to pay and require recovery from estates of deceased recipients with substantial assets.

The AMA supports the Medicaid program as a health care coverage policy of last resort for those earning below 200% of a state adjusted poverty level. This proposal is consistent with that policy, and we recommend support.

Third Party Liability - This proposal would establish a central clearinghouse to identify third party liability and would ensure that the appropriate insurer paid for care. All federal health care programs would participate. Employers would be required to verify the existence of health insurance information and initiate payment by the appropriate payor.

The AMA supports this provision as it is consistent with support for the Medicare secondary payor programs. Problems have been identified where physicians and others without adequate information having the responsibility of determining liability, and this proposal could address this concern.

ADDITIONAL MEDICARE AND MEDICAID PROPOSALS

MEDICARE

Duplicate Payment Offset - The Bush Administration proposed this Part A reduction in 1991. This proposal called for the elimination of hospital payments that are offset by the amount of separate payments made to direct billing non-physician practitioners whose services are considered in setting the PPS update. This was projected as saving $10 million in FY 1992.

The AMA again supports this proposal.

State and Local Employee Coverage Expansion - The Bush Administration made this proposal in 1991 and 1992. This would require state and local government employees hired prior to April 1, 1986 to be included under Medicare. In 1991, this proposal was projected as generating $1.2 billion in revenues in FY 1992.

The AMA supports taking this initiative. The proposal is consistent with the concept of universal Medicare coverage for all people eligible by reason of age. With most of these workers likely to be eligible for Medicare by reason of other employment prior to reaching age 65, it does not make sense to allow this special exemption.

Increasing the Age for Eligibility - When the AMA developed its proposal to restructure the Medicare program (in the late 1980's), an element of this proposal was support for an increase in the age used for setting Medicare eligibility. This proposal called for an eight year, phased-in increase in Medicare eligibility to age 67. The proposed rate for this change was set at three months per year.

The rationale for this change remains: it is a fact that the age of eligibility for federally funded health care for the elderly is arbitrary, and changing trends in terms of employment, health status, and longevity of our citizens should be recognized. Since this was proposed initially in the mid-1980's, there has been greater application of the Medicare Secondary Payor program and increasing the age of Medicare eligibility actually is closer to reality.

MEDICAID

> Parent Responsibility - States would be required to have noncustodial parents maintain health insurance coverage for their children.

The AMA previously considered this Bush Administration proposal in 1992, and recommended support. This is consistent with many ongoing state initiatives, and it also is good policy.

CONCLUSION

The Medicare and Medicaid programs provide vital health and medical services to more than 60 million Americans. Substantive changes in program operation should be made in a comprehensive fashion within the context of the needs of the beneficiaries, not put together just to meet a budget reconciliation target. This is especially important as we negotiate our way to national health system reform.

At this time, I will be pleased to answer questions that you may have.

Mr. WAXMAN. Thank you, Dr. Schenken. Dr. Ebert.

STATEMENT OF PAUL A. EBERT

Mr. EBERT. Thank you, Mr. Chairman. I am Paul Ebert, of the American College of Surgeons. I think most of the comments that we have submitted have already been made. I would just like to amplify several.

Obviously, the assistant at surgery proposal for a single fee paid to a surgeon, we think, is a very bad idea. We have opposed it in the past. It's not new. It represents a very small amount of total dollars. The College worked with HCFA over 2 years ago and created a list of the entire CPT book. That showed about one-third of the time an assistant was needed in an operation and about one-third of the time they were not. The other third, it was always should be left to the discretion of the surgeon.

As you know, many of the surgical fees in the last few years have been reduced significantly, and the surgical assistant fee was reduced from 20 percent to 16 percent. In rural America it's very difficult to, in many situations, for a surgeon to obtain services of an assistant, at least a physician type assistant. These fees are 16 percent, and some of the fees are extremely low.

Although it may work well in an organized managed care situation or an HMO, where a capitation plan is in place and during elective operations an assistant may be provided by non-physicians. It certainly doesn't work well in the rural areas, trauma cases and situations where you have to find someone, it's doubtful that you are going to do very well if you don't have a fee for them.

We would definitely and strongly oppose the concept of paying the surgeon a single fee and asking them to pay another physician for that. I think that entices the individual not to use an assistant many times when they should. We have always believed that the 5 percent rule and so forth that has been used, that if the surgeon feels they need an assistant and can justify it, my goodness it seems silly to say that you can't have one provided.

I don't think many of you sitting there would care to have a really major operation done and not have an assistant available or have someone assisting a surgeon that was not very well trained. This does happen.

I think in the same light, to amplify a little of that, we supported this effort to Medicare volume performance standard. Surgery has come in under their estimate in 1992 and will probably be under it considerably in 1993. The assistant at surgery dollars are in that same budget, so to speak, so it seems that even under the current plan it is not going over that amount.

I just would like to make one comment about the MVPS. We went into this with the concept that 3 years ago there was great concern about volume of services performed. The RBRVS had established a fixation on pricing of particular entities and consequently, when one looked now at where would changes occur it could only change from increasing volume or decreasing volume. It might be changing of services as Dr. Eisenberg mentioned, but in the calculation of the formula for the MVPS for each year there is a technology request made of how you see in your own fields where the technological advances and changes would be.

The College has submitted a report to HCFA for the last 3 years relating what we anticipated to be technological changes and what effect they would have on surgery.

We felt that the most important part of the MVPS was that it brought the profession in and got them somewhat responsible for at least looking at volume of services in their own areas. We have looked very critically at this at a State level. We have done several programs and are doing two next month, to try to compare the indications for operations between the same operation in what we would say are two States, one doing high volume and one doing low volume. We don't know which one is right or wrong.

We would like to see if we couldn't figure out ways to decide how you can influence behavior one way or the other, whichever turns to be correct.

We think that if there was to be a direction of change in this, it would be better to get more of the profession interested as we say, in concerns about our own changes in practice pattern because I think behavior does alter this.

Obviously, we do think that you have reasonable control so to speak, over the total budget in Medicare at the moment. We think the RBRVS is, like many of our colleagues, has a good and bad to it. We did ask and suggested that if there is concern about the two separate MVPS' there is some concern that possibly surgical services—let's say services performed by surgeons in the evaluation of management component—probably ought to be shifted back into the surgical target. We proposed that originally but HCFA did not have the capability by their computer system at that time to perform that.

We believe we could get more of the specialties to look at their own volume services each year. Thank you.

[The prepared statement of Dr. Ebert follows:]

STATEMENT

of the

AMERICAN COLLEGE OF SURGEONS

to the

U. S. House of Representatives

Committee on Energy and Commerce

Subcommittee on Health and the Environment

presented by

Paul A. Ebert, MD, FACS

RE: President Clinton's FY 1994 Budget Proposals

March 31, 1993

Mr. Chairman and members of the subcommittee, I am Paul A. Ebert, MD, FACS, Director of the American College of Surgeons. On behalf of the College and its more than 53,000 Fellows, I am pleased to have this opportunity to comment on some of the Clinton Administration's fiscal year 1994 budget proposals relating to the Medicare program.

Single Fee for Surgical Procedures. The Administration is asking this committee to approve a provision directing Medicare to pay the same amount for a surgical procedure regardless of whether the primary surgeon uses a physician as an assistant at surgery. Under the proposal, Medicare would reduce payment for the primary surgeon by the amount of any separate payment for the assistant. Of course, as you know Mr. Chairman, this is not a new proposal. It is the same bad idea that was recommended to you by the Bush Administration three years ago--and rejected by this committee. The College is just as strongly opposed to this proposal now as then, because it is still fundamentally inconsistent with the concept that Medicare should pay for physicians' services that are required by Medicare patients.

In 1990, in lieu of the single fee plan, Congress adopted two provisions relating to assistants at surgery under Medicare. One of these provisions eliminated any payments for assistants when program claims data indicated that they were used for an operation less than 5 percent of the time. This provision assumes that if an assistant is used infrequently for an operation, then an assistant must not be necessary. However, the fact that a service may be required by less than 5 percent of the Medicare population has no bearing on the needs of a particular patient. Therefore, we still believe that the program should pay for medically necessary assistants at surgery, no matter how frequently or infrequently they are required for any operation. However, we have worked with the Health Care Financing Administration (HCFA) to implement this unfortunate provision in the least disruptive way possible.

A second provision reduced the payment amount for an assistant at surgery from 20 to 16 percent of the primary surgeon's global fee. The College was very concerned about the effects of this provision on the availability of assistants, especially in areas where such assistants must travel long distances. In its 1992 report to Congress, the Physician Payment Review Commission (PPRC) noted that the 16 percent rate was lower than the resource costs involved for many operations. The Commissioners also warned that "when combined with reductions in payments for surgical procedures, the 16 percent rule may make it difficult for surgeons to recruit assistants." Unfortunately, many surgeons across the country are reporting that, in fact, it is becoming increasingly difficult to secure assistants at surgery.

Mr. Chairman, the decision to use an assistant at surgery depends on the complexity and difficulty of the procedure, as well as the condition of the patient. Some operations, such as laparoscopic cholecystectomies, require four hands. Other operations rarely require an assistant. The health status of the patient also is a critical factor, and the primary surgeon may determine that using an assistant at surgery will reduce the risk of mortality or morbidity. Reducing operative time is especially important in minimizing the risks for those older Medicare patients who are in poor overall health.

While Medicare has a legitimate interest in evaluating the appropriateness of the use of assistants at surgery, the program also has the responsibility for paying for the needed professional services that Medicare patients require. In addition, we believe it is important to point out that, in 1990, Medicare payments for assistants at surgery equaled less than one percent of the total allowed charges for Medicare Part B for that year, based on BMAD data that were provided to us by HCFA. This budget proposal only introduces unwarranted economic pressures on what should be medical decisions about the safety needs of the patients who require operations. The proposal is inappropriate and again should be rejected.

Resource-Based Practice Expenses. The Administration is proposing what they call an "interim" step toward a resource-based system for practice expenses in the Medicare fee schedule. A more comprehensive phase-in to a resource-based system would start in 1997. The College has been, and remains, opposed to using this so-called resource-based methodology for practice expenses under the Medicare fee schedule. We have steadfastly opposed the resource-based approach, because it is a method that focuses on efforts, not results. It is a system that sets values for services regardless of outcomes or quality. We see no reason to expand the use of such a methodology to the practice expense component of the Medicare fee schedule.

As you know, a very extensive redistribution of physician payments under Medicare occurred after the implementation of the so-called resource-based relative value scale, and the effects of these changes are neither complete nor fully evaluated. The College fears that extending the so-called resource-based method to practice expenses would cause further massive reductions in fees for many surgical and other services, without any assessment of the implications such changes may have for Medicare patients or their physicians. We are particularly concerned about the potentially devastating impact that such a scheme most assuredly would have on small surgical practices throughout much of the country, and especially in many rural areas where continued access to surgical and other services would be threatened. We believe that access to surgical care is as important as access to primary care services in rural areas. Moreover, for many primary care physicians and hospitals, access to surgical specialists is essential in order to maintain the fragile health care systems in rural areas.

It also should be clear from the advice provided to you by the PPRC that the information base to evaluate or implement this kind of major payment change--even if the expected effects on your constituents were known--does not exist. In our judgment, payment changes of the kind envisioned in the proposal should not be approved even on an "interim" basis until at least some basic questions about this plan are answered and understood.

Medicare Volume Performance Standards. The Administration has proposed modifications in certain features of current law that pertain to the Medicare volume performance standards (MVPSs). As you well know, Mr. Chairman, the American College of Surgeons was, and remains, a very strong proponent of performance-based approaches to address the concerns of policymakers about the volume and intensity of services provided under the Medicare program. In fact, we do not believe that physician payment reform could have been approved unless it was accompanied by some mechanism resembling the MVPSs.

The College is convinced that volume performance standards, including a separate, identifiable standard for surgical services, are a very effective means of focusing the attention of the physician community on the utilization of their services. Obviously, we have been very pleased that the surgical community was successful in meeting the surgical MVPS goal for the 1993 update. The challenge now is to make the MVPS concept work for all of medicine.

Despite our support for the MVPSs, we recognize that we have had very limited experience with this new expenditure target tool. For this reason, we have urged caution in the development of any major changes in the design of the MVPSs, such as structuring the standards on something less than a nationwide basis or covering unduly narrow categories of services. But, based on what we have learned thus far, we urge you to consider two important changes in the measurement of performance under the MVPS for surgical services that will strengthen its effects.

First, the College supports a modification of the definition of surgical services for the purposes of setting the surgical target to include all services performed by surgeons, not just their procedural services. By making this change, for example, expenditures for surgeons' separately identifiable evaluation and management services would be removed from the nonsurgical expenditure target and charged against the surgical MVPS.

Second, the College supports amending the current system to establish a separate MVPS and fee schedule update for primary care services. This change would allow policymakers to consider volume issues relating to justifiable increases in the number of primary care visits under its own separate performance standard, at least until definitive medical necessity criteria, practice guidelines, and/or a workable system of physician profiling can be developed to judge the appropriate utilization of those services.

The College remains unalterably opposed to the establishment of state-level volume performance standards, because we believe that such an approach only will introduce major political pressures over the annual allocation of resources for physicians' services under what is essentially a national program for the elderly. It is a well-known fact that many patients are referred to, or otherwise obtain the services of, physicians (particularly specialists) from outside of their own communities and states. Political boundaries should not distort reasonable attempts to establish expenditure targets for physicians' services.

Because we do not have the specific details of the proposals from the Administration relating to potential reductions in the MVPSs, we are not able to make a full assessment of these recommendations. But, as a matter of policy, the College is very concerned about any changes that tend to erode the underlying performance-based concepts inherent in the MVPSs. Obviously, for example, if future performance standards are set for Medicare without any real concern about the expected effects of factors that actually determine the expected rate of growth in physician expenditures, then the ability of surgeons and other physicians to meet such standards will be compromised. We also are concerned about possible changes that might make the "default" formulas more attractive than the explicit setting of targets and updates after careful consideration of all the issues involved, not just budget goals alone.

1994 Fee Schedule Updates. The Administration proposes a full fee schedule update for calendar year 1994 for primary care services only. For other physicians' services, the update would be two percentage points below the full update. We are completely opposed to this proposal. Why the continued discrimination? Medicare now has adopted a fee schedule that was supposed to redress the alleged imbalances in the relative values for various categories of physicians' services. In addition, at least insofar as surgical services are concerned, surgeons have met much more restrictive Medicare volume performance standards than have been applied to other physicians' services. The College believes that differential updates in fees should be based only on performance. If Congress feels obliged to reduce payment updates as part of a broad budgetary reduction plan, then these reductions should be made equally for all services covered by the program--that is, a truly "shared sacrifice" among all physicians.

Physician Supply. Finally, the Clinton Administration has made a number of proposals relating to the financing of graduate medical education (GME) under the Medicare program. The College believes, Mr. Chairman, that the Congress should consider GME financing issues only after it has had an opportunity to fully reexamine national physician supply and training policies in the context of health care reform. GME financing should not be dealt with in isolation or in a piecemeal manner as outlined in the budget proposals.

The College has taken no position about the precise physician-to-population ratios that would best meet the nation's physician supply needs, nor have we determined the most appropriate mix of physicians among the medical and surgical specialties. These goals should be established only after a more careful assessment is made of the potential implications of health reform on the ways in which medical and surgical services are organized and delivered.

But we believe there is a need to consider a reduction in the total number of residency positions currently available and to reconsider the rationale for maintaining such a large number of postgraduate positions that are now filled by international graduates. The College believes that establishing specific numerical limits on the number of physicians to be trained is the best way for policy makers to determine the future mix and numbers of medical and surgical specialists. Under this approach, the various Residency Review Committees would have responsibility for establishing the program criteria that would work best within the national supply targets. In our view, only this type of approach will send the clear signal that is needed to redirect the government's policies to finance GME.

We also believe that once determinations on the numbers of positions have been made, it should be the policy of the government to adequately fund residencies throughout the entire course of the training program. It makes no sense at all to fund some residencies only for a portion of the residency period. If we commit ourselves to establishing the number of physicians we want to train, it seems only reasonable to support that training for the full residency period. I hope you will consider adopting national physician supply goals through these more direct means.

Again, the College is pleased to have this opportunity to comment on the Clinton Administration's budget proposals. Mr. Chairman, I would be pleased to respond to any questions you or the subcommittee members may have.

Mr. WAXMAN. Thank you, Dr. Ebert. Dr. Wallace.

STATEMENT OF K.K. WALLACE

Mr. WALLACE. Thank you, Mr. Chairman. I practice radiology in Charlottesville, Va. I am pleased to present the following testimony related to the 1994 Medicare budget.

The ACR is concerned that the administration's 1994 budget proposals are ill conceived and fail to address the problems the administration claims are inherent in the Medicare payment system. The most egregious proposal in the budget would bundle payments for radiology, anesthesiology and pathology into single payments based on diagnosis related groups, perhaps DRG.

We are surprised that the administration has chosen this failed proposal of the previous administration, to include in the current budget. Congress has rejected this notion on several occasions, including proposals in 1965, 1972 and 1987. After your deliberation of the RAP's idea in 1987, you sponsored a provision of the law that specifically prohibits implementing such a system.

We strongly urge you to reject this proposal for the fourth time. Administration claims that the justification for the RAP/DRG proposal is over-utilization and increased utilization of radiology services in the in-patient hospital setting, and it attributes this increase to radiologists. This contention ignores the facts. Data from the Health Care Financing Administration show that extraordinary increases in volume of services in radiology in the in-patient hospital setting are not attributable to the radiologists but to non-radiologists performing radiology services.

Virtually all radiological procedures performed by radiologists are ordered by referring physicians. The situation that Congressman McMillan alluded to a few minutes ago in CT's and so forth, radiologists do not order those.

The larger increases in radiology services have taken place in the outpatient and hospital and office settings. Further, we note that the increase in utilization of radiology services has occurred because of the instance of self-referral by a non-radiologist for a diagnosis and treatment.

We are pleased that the budget addresses an important facet of the self-referral problem, with a revision which would bar physician referrals to facilities in which they have ownership interest. For almost a decade the ACR has raised this issue, and we are pleased that recognition of this problem has now gotten almost universal acceptance. This is only part of the problem.

Based on Medicare data and peer reviewed studies, we found that the growth of self-referral by a non-radiologist has been substantial. We believe that the Members of Congress must address this utilization problem which has significant budget implications. In Medicare alone, we estimate the savings of at least $200 million per year.

Where there is inappropriate utilization we stand ready to define a system to eliminate it. Work has begun on such a system. To complete this work we are willing to expend the same efforts and resources as we did in developing a fee schedule for Medicare payment. We believe we are uniquely positioned in the health care delivery system, to develop patient care guidelines for a diagnostic and therapeutic radiology.

Because of our consultative role in medicine patients are seen on a referral basis, and the inherent conflict of interest, this can be avoided. One way to address this problem is though the development of diagnostic patient care guidelines. These guidelines would identify what procedures are most beneficial to patients. The guidelines could also identify procedures which are most cost effective.

We believe that such guidelines would produce significant savings in the health care system with no negative impact on the quality of care given patients. We also believe that such a system would provide for the most appropriate care by physicians, who are best trained to provide the care.

It is essential that any system of patient care guidelines be unambiguous, so there can be easy compliance and monitoring. There must also be meaningful reform of the professional liability environment if guidelines are to work. Many States have adopted changes in their laws to reform professional liability, and we urge the Congress to assist in this effort.

We also urge you to adopt changes in the fraud and abuse laws which will make compliance with these laws easier and more meaningful. The ACR believes these initiatives are realistic recommendations to deal with the problems of cost and over utilization of radiology services. Simply bundling RAP payments does nothing to address the issues of inappropriate utilization of services, nor does it provide any safeguards to assure patients have access to the most appropriate care.

The ACR has a proven track record of working with this subcommittee, the Congress and the Health Care Financing Administration, to develop meaningful changes in the physician payment system. We look forward to working with the Congress and the Administration, to address concerns with the health care system.

We will be happy to supply data concerning our ideas for your review. Indeed, with permission, we will append supporting research projections and references in our written testimony. Our proposals will address your deficit reduction goals in more appropriate ways than those submitted by the administration.

Thank you, Mr. Chairman.

[The prepared statement of Dr. Wallace follows:]

Statement of the

American College of Radiology

The American College of Radiology is pleased to present the following testimony for the record of the Energy and Commerce Committee Subcommittee on Health and the Environment on issues related to the 1994 Medicare Budget.

The Administration's budget for federal fiscal year 1994 contains recommendations for further significant reductions in federal spending for Medicare. The ACR is concerned that these deficit reduction proposals are ill-conceived and fail to address the problems the administration claims are inherent in the Medicare payment system. The budget proposals ignore the tremendous efforts of medical groups, such as the ACR, who have worked in good faith with the Congress to address cost and payment concerns with the Medicare program.

The ACR has a proven track record of working with this subcommittee, the Congress and the Health Care Financing Administration to develop meaningful changes to the physician payment system. We expended tremendous efforts and resources to develop a fee schedule and a methodology for appropriate changes and modifications to it. We are pleased to note that much of our methodology for updating relative values was incorporated by the American Medical Association in its system for reviewing relative values and we are pleased to participate with the rest of medicine in that process.

The Administration now proposes to ignore these sincere efforts on the part of medicine. We believe the budget recommendations would have the effect of canceling our collective efforts to reform the physician payment system. Further, we believe that these recommendations are premature. Based on the most current data on volume performance standards, there seems to be a moderation in increases in physician payments in the Medicare program.

The most egregious proposal in the budget recommendations is that which again recommends bundling payments for radiology, anesthesiology and pathology into single payments based on diagnosis-related groups. We are surprised that the Administration has chosen this failed ill-conceived proposal from the previous Administration to include in its current Medicare budget recommendations.

The Congress has rejected this notion on several occasions including proposals in 1965, 1972 and 1987. After your deliberation of the RAPs idea in 1987, you sponsored a provision in the law that specifically prohibits implementing such a system. We strongly urge you to reject this proposal for the fourth time.

The Administration claims the justification for the RAPs DRG proposal is over-utilization and increased utilization of radiology services in the in-patient hospital setting and attributes the increase to radiologists. This contention ignores the facts. Data from the Health Care Financing Administration shows that extraordinary increases in volume of services in radiology in the in-patient hospital setting is not attributable to radiologists, but to non-radiologists performing radiology services. Virtually all radiological procedures performed by radiologists are ordered by referring physicians. Secondly, the larger increases in radiology services have taken place in the out-patient and office setting. Further, we note that the increase in utilization of radiology services has occurred because of the incidence of self-referral by non-radiologists for diagnostic testing and treatment.

We are pleased that the budget recommendations address an important facet of the self-referral problem with a provision which would bar physician referrals to outside facilities in which they have ownership interest. For almost a decade, the ACR has raised this issue and we are pleased that recognition of this problem has now garnered almost universal acceptance. The ACR is pleased to have played a role in the AMA's adoption of a policy statement which addressed the abuse of these self-referral arrangements. We hope that 1993 will be the year for passage of legislation addressing joint venture self-referral. But, this is only a part of the problem.

Based on Medicare data and peer-reviewed studies, we find that joint venture self-referral is only a small portion of the self-referral problem. We are submitting these data and studies for the record. The growth of self-referral done directly by non-radiologists has been substantial. We believe that medicine and the Congress must address this utilization problem which would result in significant budget savings. In the Medicare program alone, we estimate scorable savings of $200 million annually.

Where there is inappropriate utilization beyond self-referral, we stand ready to define a system to eliminate it. Work has begun on such a system. To complete this work, we are willing to expend the same efforts and resources as we did in developing a fee schedule for Medicare payment. We believe we are uniquely positioned in the health care delivery system to develop patient care guidelines for diagnostic imaging and therapeutic radiology. Because of our consultative role in medicine, we take patients on referral and therefore conflict of interest is avoided.

One way to address this problem is through the development of diagnostic patient care guidelines. These guidelines would identify what procedures are most beneficial to patients. Guidelines also could identify which procedures are most cost-effective. We believe such guidelines would produce significant savings in the health care system with no impact on the quality of care given patients. We also believe that such a system would provide for the most appropriate care by physicians who are best trained to provide the care. It is essential that the system of patient care guidelines be unambiguous so there can be easy compliance and monitoring.

There must also be meaningful reform of the professional liability environment if guidelines are to work. Many states have adopted changes in the law to reform professional liability and we urge the Congress to do the same. We also urge you to adopt changes in the fraud and abuse laws which will make enforcement of these laws easier and more meaningful, and we support the chairman's efforts in this regard.

The ACR believes these ideas are realistic recommendations to deal with problems of cost and over-utilization of radiology services. Simply bundling RAP payments does nothing to address the issues of inappropriate utilization of services nor does it provide any safeguards to assure patients have access to the most appropriate care.

Our second major concern with the President's budget proposals is the recommendation to arbitrarily change the updates for Medicare physician payment. The RBRVS fee schedule was adopted to correct perceived inequities in physician payment. We believe it is inappropriate to change the system of updates which would effectively change the basis of a fee schedule that is not fully implemented and is still in the process of refinement.

The Congress, the previous administration and the medical community expended considerable time, money and effort working together to develop a payment system for physicians that addressed perceived inequities in payment among physicians and among different localities across the country. Even though this fee schedule is only half way through the process of implementation, several proposals from the administration involve changes which would completely destroy the basis of the fee schedule. It is important to continue this transition to full implementation of physician payment reform including refinement of geographic practice cost differences and study of resource based practice costs.

An additional problem with the Medicare fee schedule includes the previous administration's contention of a behavioral offset in response to changes in payments. We recommend fixing this and other problems with the fee schedule rather than throwing it out and starting over.

The ACR's third concern with the budget proposal is related to funding for training physicians. We believe it is inappropriate to arbitrarily decide that funding for training specialists should be reduced. The need for specific specialists should be based on need and not perception. Changing the supply of specific specialties is not a panacea for eliminating inappropriate utilization of medical services. It is more appropriate to determine need for services and provide sufficient numbers of specialists to meet those needs. This will also allow for provision of the most appropriate care by the best qualified physician.

In addition to the specific problems we have with the Administration's budget proposals, there is a general observation to make regarding Medicare budget considerations. We question the appropriateness of discussing recommendations for policy changes in the Medicare program when the administration has not yet completed its work on the anticipated plan for reform of the health care delivery system. Some of the President's budget proposals raise policy issues that may be incongruent with proposals for health care system reform.

We will be happy to supply data concerning our ideas for your review. Our proposals will address your deficit reduction goals in a more appropriate way than those submitted by the administration.

As we have in the past, the ACR looks forward to working with the Congress and the administration to address concerns with the health care system.

Mr. WAXMAN. Thank you, very much, Dr. Wallace. Dr. Graham.

STATEMENT OF ROBERT GRAHAM

Mr. GRAHAM. Thank you, Mr. Chairman. I am Bob Graham, the Executive Vice President of the American Academy of Family Physicians. I would like to comment on several elements of the administration's proposal before you this morning, a number of those elements you have heard touched on by previous speakers.

We do recognize that it is a time of transition and that there is an overarching context that we have to look at this proposal in, recognizing that many major changes in health care reform will be proposed within the next 2 to 3 months and become actively debated in the Congress. Many of our comments are focused on what we think is good policy, not only in the context of the 1994 administration submission, some of which appears to carry policies carrying over from the prior administration, but also what we think will be important to face as we look at health care reform.

I will identify three areas of comment. First, the relative value schedule. We do not believe there should be any delay in the update. We believe that the difficulties that that would cause for physicians particularly on the evaluation and management area, would be onerous and would not be welcomed, and would cause further erosion of any confidence that may have been initially in the RVS system as a more equitable basis of payment. Substantial erosion, as you are already aware, has taken place.

The movement towards including a resource based practice expense in the RVS, we think, is very important. But we do have concerns about the way the administration has proposed to do it. It appears that it is both asymmetric as Dr. Eisenberg discussed with you, and also would remove substantial sums from that component before the test of budget neutrality for redistribution was placed. This is something we encountered with the original RVS implementation, and has turned out to be very troublesome.

The issue of how many MVPS there should be, I think, will not go away. In many senses we feel that the profession would be better off with only one MVPS. The Congress made a commitment when they went into the RVS, to have two MVPS. The way that is playing out now causes us to feel that the right answer is an odd number. It's either one or three. The two is not working out very well. If we can't go to one, then we do believe that you do need to look at a third MVPS for evaluation and management services, which obviously and historically are not growing anywhere nearly as much as some of the other services.

The second area that I would address is GME. We think that many of the recommendations in the administration's proposal to you regarding GME go in the right direction. Public funds and Medicare funds should support graduate medical education to the extent that the products of that graduate medical education meet a public need.

We have identified that we have an under supply of generalist positions, family physicians, general internists, general pediatricians, and over supply of sub-specialists. So, using Federal tax dollars of GME funds to support a re-balancing of the system so that there are clearer incentives or support for training more of the generalists, we think is absolutely appropriate.

The third area that I would identify just in closing, is the recommendations for reduction in payment for lab services. This, again, I think is an example of how short term attempts to micro manage and to save small amounts of money just drive the small office based practitioner absolutely nuts. The whole CLIA experience has been an extraordinarily negative one for physicians in office practice. It has been an inappropriate mismatch of regulation to a circumstance which was supposed to provide patience convenience and good quality of care.

Now, to suggest that the payment for these services should be further reduced or discontinued, just is adding insult to injury.

Sir, with those comments I will conclude, and be happy to respond to any questions.

[The prepared statement of Dr. Graham follows:]

STATEMENT OF ROBERT GRAHAM, EXECUTIVE VICE PRESIDENT, AMERICAN ACADEMY OF FAMILY PHYSICIANS

I am Robert Graham, M.D., and it is my privilege to serve as Executive Vice President of the American Academy of Family Physicians. On behalf of the Academy's 74,000 members, I wish to express our appreciation for this opportunity to appear before the Subcommittee and to comment on the Medicare provisions in President Clinton's proposed budget for Fiscal Year 1994.

The larger context in which the Administration has proposed its FY94 budget challenges us to consider this budget from a new perspective. This is particularly true in regard to the Medicare provisions. In general, the budget must be considered as part of the President's three-pronged strategy to revitalize the American economy. The Medicare budget, in particular, must be considered in the context of the Administration's efforts to reform the American health care system. We recognize that a simple arithmetic assessment of how the proposed Medicare cuts will impact on the financial well-being of family physicians fails to do justice to the fuller implications of this proposed budget.

In formulating our response to this year's budget proposal we have taken our lead directly from the President, who has asked for a shared sacrifice to achieve the combined goals of deficit reduction, short-term economic stimulus, and long-term investment in the economic infrastructure. We choose to view the Medicare provisions as part of a wide-ranging set of spending cuts and tax increases designed to ensure that no one sector of the economy is unfairly singled-out. We do not believe that health care or health care providers possess a special status that should automatically result in an exemption from this nation's collective responsibility to ensure its future economic health.

Having said this, I hasten to raise the Academy's long-held concern about unjustifiably low Medicare payments for primary care services. Our estimates suggest that Medicare fees for office visits, which are the services most frequently provided by family physicians, are often below cost. The extent to which the budget proposal might push fees further behind costs only serves to exacerbate the problem.

As noted earlier, the President's three-pronged strategy for revitalizing the American economy includes a package of investments designed to bolster the infrastructure for long-term economic growth. Another essential aspect of the President's economic revitalization program is reforming the American health care system by bringing health care costs under control and ensuring universal access to appropriate health care services. The President has repeatedly demonstrated his clear understanding that the success of health system reform rests on a substantial upgrading of the availability of primary care services. Indeed, many of the current problems in the American health care system can be directly attributed to the decades of neglect suffered by this country's primary care infrastructure. This neglect can no longer be sustained if every American is to be assured access to appropriate health care and if health care costs are no longer to constitute an ever-widening drain on the American economy. My message today is a simple one. As you consider the difficult choices presented in the Administration's budget proposal, you must recognize, as the President has recognized, that rebuilding of the primary health care system is an essential investment in the economic infrastructure of this country.

The Clinton Administration has adopted an approach to reducing the federal budget deficit that is noteworthy in two important aspects. First, the Administration has avoided the temptation to limit its FY94 proposal to budget cuts and has, instead, included well-targeted investments in the economic infrastructure. A meaningful reduction in the deficit can probably only be achieved through a combination of budget cuts and economic growth. We believe the long-term investments proposed in the President's budget can provide a foundation for economic growth that might not otherwise occur.

Second, the Administration has expressed a clear intention to tailor its proposed cuts in the Medicare budget to be consistent with its vision for health system reform. In this regard the Administration has clearly recognized that controlling health care costs and achieving universal access will require a substantial upgrading of the primary care infrastructure. Specifically, this will require a substantial change in the specialty and geographic distribution of physicians. From the current ratio of 70 percent specialists to 30 percent generalists must be achieved an equal distribution between specialists and generalists. Furthermore, the geographic distribution of physicians must more closely approximate that of the general population.

Consistent with this recognition, the Administration's proposed budget includes several provisions that appear to either exempt primary care services from budget cuts or reorient existing financial incentives to encourage the greater availability of primary care services. The level of detail regarding the Medicare provisions in the proposed budget is not sufficient to fully assess their eventual impact. The following comments on a few specific provisions should be regarded as preliminary until such time as more detailed proposals are available from the Administration.

Graduate Medical Education Payments - The analytic basis for reducing indirect medical education payments stems from several well-publicized analyses suggesting that the current indirect rate exceeds the added patient-care costs associated with medical education. The proposal for reforming and rationalizing direct medical education payments would standardize the per-resident amount based on the average annual resident salary, weight direct payments substantially in favor of residents in the generalist specialties, and reduce DME payments by setting weights below a budget-neutral level.

We are concerned that the proposed reductions in the IME payment rate may have a perverse impact on generalist residencies. Faced with a reduction in IME payments, hospitals are likely to target cut backs on those residency programs that bring in the least revenue, which tend to be in the generalist specialties.

The proposed reweighting of direct payments would set an important precedent and is entirely consistent with the direction of health system reform. However, the Academy believes that a much more radical reform in GME payments will be necessary to correct the severe specialty and geographic maldistribution. Despite the fact that medical care is increasingly ambulatory in nature, Medicare GME payments are funneled exclusively through hospitals and tend to more richly reward programs training the procedural and surgical subspecialties. The Academy believes that Medicare GME must be unleashed from its exclusive link to inpatient facilities. Ambulatory training facilities should be eligible for both direct and indirect medical education payments. These changes can be accomplished in a budget-neutral manner. However, the proposed reduction in GME payments will make the necessary changes in GME funding more difficult to achieve. As long as the overwhelming majority of Medicare GME dollars flows to hospitals there is little reason to expect any significant change in graduate medical training.

Physician Fee Update - The Academy believes the exemption of primary care services from the proposed reductions in the 1994 fee update to be consistent with the intent of the Medicare fee schedule and with the policy of promoting primary care. It is our understanding that a moderation in the growth in the volume of Medicare physician services in 1992 will result in a higher update in 1994 than has occurred in recent years. We are concerned that the proposed reduction in the update will violate an agreement established with Medicare physician payment reform. As noted above, our concern is moderated to the degree that the proposed reduction may be linked to the larger health system reform effort.

Medicare Volume Performance Standard - The Academy is concerned that the proposal to lower the floor in the MVPS default formula will have an unintended and perverse impact on primary care services. The current crude categorization of physician services into surgical and non-surgical groups places visit services, which are those most often provided by family physicians and which have experienced only moderate volume growth, with diagnostic and treatment procedures, which have undergone the most rapid growth in volume. For the purposes of the MVPS, we believe an additional category of physician services should be established for visits. The creation of an additional visit category will protect primary care services from a recurrence of the unjustifiably low update received for 1993.

Resource-based Practice Expense Phase-in - The Academy has long supported the resource-based practice expense payment method developed by the Physician Payment Review Commission, which would correct an egregious inequity in practice cost reimbursement. The current method of calculating practice expense payments relies on historic costs and incorporates traditional inequities that physician payment reform was intended to correct. Inadequate Medicare practice expense payments for office-based visit services has had a chilling effect on the willingness of family physicians to take on new Medicare patients.

While we appreciate the Administration's tacit support of the PPRC proposal, it is important to note that PPRC called for a budget-neutral implementation, whereby payments for overvalued services would gradually decrease while simultaneously increasing payments for those practice expenses that are currently undervalued. The Administration's proposal would establish an interim step toward a resource-based method by immediately reducing practice expense payments that are deemed to be overvalued but delaying any increase in payments for undervalued services. We are concerned that this asymmetric phase-in will undermine the intent of the PPRC proposal by eliminating the funds available for eventually increasing payments for currently undervalued practice expenses. We urge the

Subcommittee to carefully consider the perverse long-run impact that this provision would have on establishing a resource-based practice expense component to the Medicare physician fee schedule.

Payments for Clinical Laboratory Services - We believe the proposal to reduce payment for clinical office laboratory services to be unjustified in view of the onerous administrative burden imposed on physician office laboratories by the regulations implementing the Clinical Laboratories Improvement Act of 1988. In our opinion the CLIA regulations fail to faithfully implement the intent of the act, bear no demonstrable relationship to quality, have substantially increased monetary and non-monetary costs for both patients and physicians, and have had a negative impact on access to appropriate laboratory services. The proposal to reduce payments for laboratory services will further exacerbate access problems. We will examine the Administration's health system reform proposal for evidence of outcome-based regulations that will supplant the unjustified and overly burdensome process-based regulations epitomized by CLIA-88.

It has been my privilege to address these important issues today. On behalf of the Academy, please accept my sincere offer to assist the Committee in any way possible in its deliberations related to the Medicare budget and the larger issue of health system reform.

Mr. WAXMAN. Thank you very much, Dr. Graham. Let me start off by indicating that all of you heard the administration recommend that a 2 percent cut in next year's update to the fee schedule except for primary care services.

In light of the potential and substantial updates based on preliminary estimates of 1992 performance, do you think an across the board reduction of about 1.7 percent for all services would be a more equitable approach to achieving the same level of savings.

Mr. GRAHAM. We would disagree with that, obviously.

Mr. WALLACE. We would respectfully agree with that, Mr. Chairman.

Mr. WAXMAN. Dr. Ebert.

Mr. EBERT. It's good and it's bad. I wouldn't oppose it.

Mr. EBERT. Dr. Schenken.

Mr. SLATTERY. Wouldn't oppose what?

Mr. WAXMAN. This idea of a 1.7 percent.

Mr. SCHENKEN. We think you are caught in a Catch 22 on this. There are certain geographic areas, there are certain specialty areas, there are certain problems, intercity and so forth, where you would like to go the other way. However, the overall problem suggest that something uniform might be viewed as more fair than something that is non-uniform. It is a very difficult call.

Mr. WAXMAN. Dr. Wallace, you testified that rather than bundle payments for radiologists and other hospital based specialists into DRG's the College recommends the development and use of practice guidelines for radiology.

Are you working with the Agency for Health Care Policy and Research or is this an effort of the College alone, and how would you propose such guidelines be used by the Medicare program?

Mr. WALLACE. Currently, this is an effort of the College alone, as part of our educational process and gearing up for what we think the future of reimbursement. We would think that as health care reform takes place these guidelines and the use of them could be incorporated into the legislation.

Mr. WAXMAN. Dr. Ebert, you have stated the College of Surgeons strong opposition on payments to assistants at surgery. Could you tell us whether the College has criteria to determine when such assistants are required, and what kind of credentials be required for persons serving as an assistant. Should it be a physician, or are other health care professionals appropriate in some cases.

Mr. EBERT. To your first question, Mr. Chairman, I say we have already created a list through a consensus process with the various specialties. I don't think you can say in the sometimes group. There are many times an assistant is necessary depending on the severity of the illness of the patient, overweight patient or urgency of an operation, and I don't think you can ever make a total—it isn't a total, 100 and zero type of question.

With the list that has been distributed to HCFA and to all the carriers in the United States for their use if they wish to use it, our main purpose was to eliminate operations where assistants were not necessary where at times when they were being used, and to show the public that there were operations in which you always needed an assistant. I think we would address that.

The College has always had the position that the ideal assistant was another surgeon who was capable of doing the operating in case something went wrong with the operating surgeon. This is probably more purposeful in a major operation.

We also recognize though, that depending on the hospital settings and the locations around the country, that there is such a wide range of people who are really relatively qualified to serve, because we are not talking to the same magnitude of operation in every setting. In some settings we have full trained surgeons, we have residents, we have family practitioners and other types of medical specialists at times that assist. We have nurses, we have physician assistants, surgical technicians.

It's an impossible question. We recognize that they are all valuable in their own setting. We are most concerned in the setting, where they do not have access we will say, to the lesser trained individuals and one has to use a physician as the assistant. That's where the reduction in fee for service would have the biggest impact.

Mr. SCHENKEN. Mr. Chairman, could I add something?

Mr. WAXMAN. Yes.

Mr. SCHENKEN. I totally agree with the comment of Dr. Ebert. To put it in clinical perspective, in a large tertiary care institution like I serve, our surgeons are able at some times to decide that the odds of needing an assistant are very low because they have highly skilled nurses that are there assisting, and because our hospital is crawling with assistants if they ever need one right on the spot.

Out in rural Nebraska, that is not so. It would be the same patient, same circumstances, that could cause a surgeon who had one choice to say I won't use an assistant and another one to not. It's hard to write regulations. That's really the reality of patient care.

Mr. WAXMAN. Thank you. Mr. McMillan.

Mr. MCMILLAN. I think we are on a crucial point; that is, who is going to run the system. The notion behind the idea of a single payment for surgery is that the surgeon basically should determine what is appropriate. If two surgeons of equal skill are the ideal relationship in terms of an assistant when they give an operation then the question certainly arises, do they get compensated at double what one surgeon would get or do they split what the procedure calls for.

I think that is really what we are coming down to in a lot of situations. It seems to me that those who have the expertise are in the position to manage for cost effectiveness. If we don't get that out of physicians and providers, then I think what you are going to get is going to be much more onerous in the long run, and that is a bureaucratic solution to the problem by people who don't practice and have to face the consequences of their own actions. I think that's pretty crucial.

I think we need to view this in the context of, are we going to approach health care reform with respect to standards of practice that probably you provide and that the Congress doesn't or the bureaucracy doesn't, and try to live within those guidelines. I think we have to have a lot of discussion on that. It gets back to who is going to be the gatekeeper in all of this.

Under a health management organization does it not operate with standards of practice in the free marketplace?

Mr. SCHENKEN. Individual doctor's operate with standards of practice. The difficulty has been—we, and actually the Congress, has been working for quite—with all the gentlemen here and all of the other specialty societies to try to develop parameters of practice that are broad enough to accommodate the individual problems of patients and narrow enough to make sure that the most appropriate things have been done.

Mr. MCMILLAN. You can broaden that way on out, to the point where you say OK, the Government on the average is going to subsidize medical care based on average. It's going to be up to the delivery system to determine how that falls within that general guideline. It seems to me here, what we are arguing is micro managing, which is probably something that you basically don't like.

Frankly, I think it's a problem, because I don't think government is good at micro managing. That's why I think that it's such a crucial question, as to whether to focus it in on a general fee covering a surgical procedure as opposed to direct compensation of individuals that may be involved in it, is the typical kind of question.

Dr. Schenken, I haven't studied all of your testimony but it has been suggested that on page 8 you make reference to the inter-relationship of the general rate of inflation and the growth and the cost of Medicare, and suggest that perhaps they are not inter-related. I think that's a very crucial problem.

Our problem is cost. If cost weren't a problem we wouldn't be here talking about these issues. The problem for the Federal budget and probably for the average American citizen is that health care costs are rising at three to four times the rate of general inflation. Regardless of what kind of solution we come up with, we have to address that problem. We are not doing it simply because that statistic is there, we are doing it because it is forcing some real distortions on government finances and on the economy in general.

The President, himself, has said that it should be an objective, that we try to bring health care costs in line with the general rate of inflation. I would tend to agree with that as a goal. Why shouldn't we do that?

Mr. SCHENKEN. Mr. Chairman, if our testimony is written unclearly, I apologize for it. What we attempted to say is that the general rate of inflation has only a small part to do with the rise in health care costs. Utilization, aging the population, technology, expectations, liabilities, smoking, it goes on and on.

I guess where we are in agreement—we have discussed this in front of the chairman many times before—that is that we do not believe it is possible to unilaterally solve this problem by telling the doctors to go ahead and solve the fiscal problem while the engine that runs all of this thing is only in the very small part controllable by us.

What we are trying to do—I think the chairman originally said this—we are all in this thing together. My point is that any attempt to limit the increase to the general rate of inflation without a cooperative effort involving patients and doctors and hospitals and trial lawyers of all things and all kinds of other things, will just force people to do in the system what they really don't want to do. I think none of us wants a patient who has justifiable medical needs to be denied that need at the time.

It's complicated. I am not saying it's easy. That's the point we tried to make.

Mr. McMILLAN. I would simply make the point in response, that it is the business of setting budgets to set goals, and broad economic objectives can be a part of that. I think you are absolutely right, it is wrong for Congress to set a goal of limiting the rate of increase in Medicare to, say, the rate of inflation, without exploring the means with the providers of how do you get there.

I think the reason of setting a goal is the request to join with Congress who doesn't have the expertise to deal with it, and providing some of those answers which include many things that we have talked here today and that you just recently listed in your response; malpractice reform that we could talk about. I think you wanted to talk about that.

I have introduced a malpractice reform bill. We have had a hard time getting attention on that around here. It's one among many things, that have to be considered. I just wanted to clarify that, because I think it is a legitimate question to ask as a matter of public policy and as a matter of broader policy that affects the private sector, why we shouldn't accept as a goal, or trying to achieve a level of growth in health care cost, that is comparable to the general rate of inflation.

If, with respect to the Federal budget, we want to spend more of that because technology is changing, then we ought to have the guts to sit in here and vote for it specifically.

Mr. SCHENKEN. Mr. McMillan, I think that if we took a goal to limit increases in medical care costs to the general rate of inflation without taking into consideration the rate of increase in our population, aging, expectation, technology, quality of Medicare and medical care and what other people expect us to do, sooner or later that would require the profession to make unilateral decisions which were not in the best interest of the patient.

It has happened in England. It happened in Canada. I worked for the State of Louisiana for 10 years. We are on a capitated budget for the State. Twice while I was down there we ran out of money at New Orleans Charity Hospital, the largest charity hospital in the world at the time. We shut the thing down in May and April because we had no more money, and that was it.

I suspect probably I would get support from almost all of the physician organizations, we are in this thing together. If we are going to make goals then we also have to have some understanding of quality and of expectations to meet those goals. If we can agree on that, I think we could agree on the other things.

Mr. McMILLAN. Would you agree though, to help frame the debate which we are now entering into probably over an extended period of time, that if there is anything wrong with setting a set of financial goals and in effect saying we are going to do all of those things—we are going to try to engage the provider community in achieving that objective—if we can't achieve that objective, we say we are going to spend incrementally more than that because we cannot meet those objectives.

Mr. WAXMAN. I will have to have this as the last question when we get a response.

Mr. GRAHAM. Could I add to Dr. Schenken's response. Congressman McMillan, I think you have articulated some important principles. Let me add a couple to them.

We are not just concerned with cost. Cost has got our attention right now. If the total focus of the Congress or the administration is cost, then there are other engines out there and those engines are demand, expectations, system structure. We currently are accustomed to a system which has no budget and no boundary on expectations.

It is very reasonable to talk about a budget. But with that, we are going to have to talk about a boundary on expectations, expectations on the part of the patient and on the part of the providers. I heard you emphasizing budget, which I think is a very reasonable——

Mr. MCMILLAN. I serve on the Budget Committee as well, that's one reason.

Mr. GRAHAM. There has to be that concomitant focus on expectations. I think you got into it a little bit with some of your personal experiences earlier in the hearing. We have to find a way to balance that. I might be personally more in favor of indexing it to the growth of the domestic product rather than inflation.

When you look at the GNP and how we spend our funds, anything we spend on health we are not investing or spending in some other way. Inflation fluctuates for some other reasons, and I am not sure it's the best index. There has to be a budget, but there has to be some definition of expectation. I think that is an element of what I heard Dr. Schenken saying.

Mr. WAXMAN. I want to thank the four of you very much, for being here. I think your testimony has been very valuable to us. We do have tough choices, and we are all in this together.

Our next witness is Rick Pollack, Executive Vice President for Federal Relations, American Hospital Association, accompanied by Jim Bentley, Senior Vice President for Policy of the Association. We are pleased to welcome you to our subcommittee hearing. Your prepared statement will be in the record in full. What we would like to ask is if you would limit it to no more than 5 minutes for the oral presentation.

STATEMENT OF RICK POLLACK, EXECUTIVE VICE PRESIDENT, AMERICAN HOSPITAL ASSOCIATION, ACCOMPANIED BY JIM BENTLEY, SENIOR VICE PRESIDENT

Mr. POLLACK. Thank you, Mr. Chairman. I would like to make two points, very briefly. First, we are obviously concerned about the impact of further Medicare savings on hospitals and the communities they serve. While we appreciate and understand the need for shared sacrifice by all Americans including hospitals, it's important to recognize that these budget proposals will result in some genuine hardship, particularly to many small and rural and inner city hospitals who are already in financial peril.

According to the Prospective Payment Assessment Commission, average Medicare operating margins in 1990 were negative 8.3 percent, with over two-thirds of the Nation's hospitals subsidizing the cost of treating Medicare patients. I might add, that those figures are 2 years old, and the trend lines continue to go downward.

Clearly, these new budget proposals under Medicare part B along with other significant savings proposed under part A, will exacerbate this already fragile situation. It is also important to recognize that hospitals have already contributed significantly toward deficit reduction over the past decade. The last reconciliation bill enacted in 1990, took $16 billion in savings over a multi-year period yet to be completed.

In terms of specific budget proposals, we are very concerned about the cuts in graduate medical education. While there is no question that there is a need to attract physicians into primary care and, in fact, our vision of health care reform will depend on more primary care providers of all kinds than ever before, these budget proposals simply will not serve as an incentive to attract more doctors into primary care residencies. Only comprehensive reform will accomplish those objectives.

Moreover, it will make the financial situation of teaching hospitals much worse, the very same inner city institutions that provide a large portion of care to the medically indigent.

We are also concerned about the proposal to reduce payments to hospital based home health services. A recent GAO report indicated that the increased rates paid to hospitals are legitimate, and HHS itself commented that these payments reflect a broader scope of services provided to beneficiaries and their communities by hospital programs.

Furthermore, the additional cuts proposed in the area of Medicare outpatient patients billed on an already fragmented payment system that meets only short term budget needs. Mr. Chairman, I must say that we, like you, are quite disappointed that promises of using Medicare savings to help finance expanded coverage to the uninsured have already been broken.

Given what we see coming through the doors of our emergency rooms, operating rooms and delivery rooms every day, we will never understand the reluctance to use these funds as investments to provide basic health services, starting immediately with poor moms and kids.

Nevertheless, as a practical political matter, we understand that this committee must meet the savings mark directed by the budget resolution. We hope to work with you in developing a fair and responsible and balanced package that is sensitive to the legitimate needs of our most fragile institutions serving our most vulnerable populations.

At the same time, we must insist that any short term budget actions be inextricably linked to the development of a health care reform package that provides both universal access and a restructuring of the health care delivery system.

Speaking of reform, my second and final point is that if we really need to achieve more savings, it must be accomplished through real reform rather than continued tinkering with the severely broken system. As you know, we have called for a radical restructuring of the health care delivery system that would result in about as much change as any plan that has been put on the table, as much change in the way doctors and hospitals operate.

It involves providing strong incentives to establish community care networks. The networks would link together providers and other stakeholders to provide all services needed by patients, from preventive care to long term care. They would give patients a single entry and coordination point for all services, financed through integrated payment or capitation.

On the other hand, in attempting to improve the current system by puttering and achieve further efficiencies through ratcheting which is reflected in many of these proposals, it's like driving a car by looking through the rear view mirror when we should be looking through the windshield.

The truth is that creating a more efficient delivery system is the only way to achieve additional savings over the long run. A thoughtful restructuring of the health care delivery system that provides beneficiaries with a seamless system of health care security would generate savings, because it would address the inefficiencies that result from the overlap and duplication of services, it would address the issue of excess capacity, and it would address the inefficiencies created by the perverse incentives of our fee for service system that result in more and more services generated in the name of piece work and less and less services provided in the name of wellness and prevention.

Mr. Chairman, thank you for giving us the opportunity to be here today. We look forward to working with you on the paramount issue of enacting a universal health care reform measure, and a restructured delivery system. I know that your leadership will be very significant in that arena.

Again, we look forward to working with you.

[The prepared statement of Mr. Pollack follows:]

Statement of the American Hospital Association

Mr. Chairman, I am Rick Pollack, Executive Vice-President for Federal Relations at AHA. I am accompanied by Jim Bentley, Senior Vice-President for Policy. On behalf of AHA's 5,300 institutional members, I am pleased to testify today on the Medicare Part B and Medicaid provisions in the President's FY 1994 budget proposal.

I would like to cover two basic points in my testimony this morning. First, the AHA is very concerned about the impact further Medicare and Medicaid savings will have on the nation's hospitals and the communities they serve. Second, although some short-term budget savings may be necessary, it is imperative that they be linked to the long-term goal of a health care reform package that provides both universal access and a restructuring of the delivery system.

As you know, the Administration's FY 1994 budget proposals for Medicare and Medicaid are one part of an economic package that aims to stimulate the economy, create long-term job growth and reduce the federal budget deficit. We support these goals and believe it is in the best interests of the communities we serve that the nation's economy gets back on track. We further recognize that a strong economy generates job growth and health coverage in the private sector. To achieve deficit reduction and economic growth, the President has asked for sacrifices to be made. We understand that hospitals need to participate in the shared sacrifice required of all Americans in the short term to attain our shared long-term goals.

Yet, as we work toward these laudable goals, we must ensure that the sacrifice is fair and that budget decisions lead toward, not away from, a solution to our nation's health care crisis. To accomplish real and fair health care reform, everyone needs to understand how budget decisions made today will affect hospitals and their communities.

In May, when the President presents his comprehensive health care reform plan to the Congress and the American public, we will all be engaged in an important discussion about the future of our nation's health care system. While we look forward to that dialogue and are eager to work with this subcommittee and the Congress, we must ensure that existing federal programs do not undermine providers' ability to meet the legitimate needs of their patients. Purely budget-driven decisions can exacerbate our nation's health care problems and weaken the infrastructure upon which a reformed system must be built. Consequently, we need to carefully examine President Clinton's FY 1994 budget proposal in terms of its impact on hospitals and the communities they serve.

MEDICARE AND MEDICAID SAVINGS IMPACT

The President's budget proposal calls for nearly $60 billion in savings for Medicare and Medicaid over the next five years. This comes at a time when AHA estimates that for FY 1993 two-thirds of the nation's hospitals were forced to subsidize the cost of treating Medicare patients while four-fifths subsidized the cost of treating Medicaid patients in FY 1991. Many of these vulnerable hospitals provide the only access to health care services for specific populations such as the poor, elderly and rural Americans. Reductions in Medicare and Medicaid spending have exacerbated shortfalls between payments and costs in ways that hospitals cannot sustain. AHA has specific concerns about the President's budget proposals.

OUTPATIENT PAYMENTS

The proposals offered by the Administration serve only to further fragment outpatient payment policies without taking any steps toward comprehensive reform. Continued tinkering with the numerous payment systems currently used to pay for outpatient services meets short-term budget needs only. While we look forward to examining the Administration's proposal for reform of outpatient payment, we believe that only with systemic reform will these issues be adequately resolved.

GRADUATE MEDICAL EDUCATION

The President's budget proposes significant cuts in payments to hospitals that train physicians. The budget recommends basing direct medical education payments on a national per resident amount--using resident salaries only--and further modifying payments by differential weighting depending on choice of specialty. We understand the need to implement incentives to train more primary care physicians, but do not believe that paying hospitals less for training other physicians is the incentive that will most affect the choices of graduating medical students. Only long-term, comprehensive reform of the delivery and financing of health care will properly align incentives in the direction of primary care.

Cuts in graduate medical education could exacerbate the financial situation of teaching hospitals--many in our nation's inner cities--where residents in training provide a large portion of the care to the medically indigent.

PAYMENT FOR INPATIENT RADIOLOGY, ANESTHESIA AND PATHOLOGY

AHA is encouraged by the Administration's apparent commitment to aligning hospital and physician incentives as a method of controlling spending across all sites of care. In fact, a bundled payment is consistent with our vision of reform and the need for integrated payments. However, until these incentives are broad-based and the delivery system is restructured at the local level by collaborative arrangements among hospitals and physicians, hospitals should not be unfairly burdened by a federal requirement imposing a new relationship on hospitals and their medical staffs.

HOSPITAL-BASED HOME HEALTH SERVICES

The President's budget proposes to reduce payments for services provided by hospital-based home health agencies. These reductions could result in access limitations for some beneficiaries. A 1992 General Accounting Office report indicated that add-on payments for hospital-based home health agencies (HHAs) are consistent with Medicare reimbursement principles, recognizing that mandatory Medicare cost-reporting procedures result in approximately 13 percent more overhead costs attributed to hospital-based programs. In commenting on this report, the Department of Health and Human Services also pointed out that "hospital-based HHAs can offer more services to the beneficiaries and offer a continuum of care not available from freestanding HHAs . . . where hospital-based [HHA] are adversely affected by eliminating the add-on, beneficiary access to certain quality services may be reduced." It logically follows that eliminating payment adjustments that reimburse hospitals for legitimate cost differences and promote access to services are not in the best interest of the communities we serve.

MEDICAID ADMINISTRATIVE MATCH

The President's budget proposal calls for approximately $8.7 billion savings in Medicaid program changes over the next five years. AHA asks that the options for controlling future Medicaid program spending be evaluated in broader terms than simply the dollar amount of budget savings. The Medicaid program serves as the insurer of last resort for the most vulnerable of all Americans--it is the safety net for the poor and medically indigent. Reductions in a program already underfunded to the point that it can only pay 82 cents for each dollar of acute care it purchases must be carefully planned so we do not deny access to quality health care to those most in need of public support.

A significant portion of the Medicaid savings called for in the President's budget proposals will be realized through decreases in the federal portion of the administrative expense of operating the Medicaid program at the state level. This comes at a time when states are facing severe fiscal pressures. A closer look at the many different administrative functions performed at the state level shows that program administration focuses on much more than eligibility processing and claims payment. Certain administrative functions are critical to protecting the financial integrity of the program; examples include anti-fraud and abuse units, audit programs, and coordination of payment with other insurers. Limiting these activities may result in higher program costs in the long run if the states are less able to ensure the fiscal integrity of their programs.

There are other costs of reducing administrative expenditures that cannot be measured solely on a dollar basis. These are the human costs of limiting programs designed to assure that Medicaid recipients have access to high quality services. Utilization review is one type of program designed to safeguard the quality of care; facility certification/licensure is another.

AHA'S VISION FOR HEALTH CARE REFORM

The proposed Medicare Part B and Medicaid savings in the President's plan total over $24.7 billion for FYs 1994-1998. They must be viewed, however, in a broader context. Hospitals have made significant contributions to deficit reduction in past budget bills; Medicare hospital savings in the Omnibus Budget Reconciliation Act of 1990, for example, totaled almost $16 billion. And any reductions in the Medicaid program must also be subject to the keenest scrutiny to evaluate both their dollar savings and their human costs because adversely affecting the health of the elderly, poor, and indigent mothers and children is too high a price to pay for short-term stimulus of the economy.

Despite the magnitude of these savings, this year presents us with an opportunity we have not had in past years. It is imperative that whatever budget savings are ultimately enacted in the short term are accomplished fairly and that we remain focused on the long-term goal of meaningful reform that achieves universal access and a restructured health care delivery system.

Further, we must ensure that these measures do not freeze the current fragmented health care system in place. The solution to our nation's health care crisis is not in tinkering with current flawed payment systems such as Medicare PPS. Indeed, meaningful health reform can only come about through universal access and restructuring both the financing and delivery system to encourage more prudent and appropriate behavior by providers, payers, and consumers at the local level. Only in this way will we achieve universal access to needed services at a cost this country can afford.

The AHA's top priorities are achieving universal access and restructuring health care delivery around Community Care Networks.SM These networks would be consortia of hospitals and other institutional providers, physicians and other health care professionals, insurers, employers, unions and others groups.

Networks would be expected to provide patients with a broad, coordinated continuum of care, focused on improving the health status of their enrollees. In return, community care networks would be paid on a capitated basis, receiving a fixed annual payment per individual. The allocation of resources among providers within the network, including the method and level of payment to various participating providers, would be determined within each network.

Networks would give providers greater freedom to make decisions without micro-management by government payers and insurers. In exchange, networks must be accountable. Networks might provide regular reports to communities on health status improvement, patient satisfaction, and provider satisfaction with network relationships.

The AHA believes that community care networks hold the best promise for reducing inappropriate competition within our system; improving patient care; and eliminating unnecessary care, duplication of services and excess capacity. Restructuring our health care system into capitated networks will increase the focus on preventive and primary care services.

CONCLUSION

As America's hospitals prepare for health care reform they must continue to operate under the current system, complete with a flawed and inequitable Medicare program and a Medicaid program that struggles to serve as the current safety net for the medically indigent. We stand ready to work with you to achieve these goals as well as to make the difficult choices required to meet the President's goal of a stronger economy. The President has asked for shared sacrifice from all Americans, including the nation's hospitals--many of which are financially vulnerable because of continued tinkering and past deficit reduction efforts.

We have worked with our members to develop a constructive approach to respond to the nation's health care crisis and look forward to working with you and the Administration in the months ahead. AHA is committed to meaningful health care reform that achieves universal access and a restructured health care delivery system.

SM - CCN, Inc. and San Diego Community Healthcare Alliance use the name Community Care Network as their service mark and reserve all rights.

Mr. WAXMAN. Thank you very much, Mr. Pollack and Mr. Bentley. Let me ask you both this question. Has the American Hospital Association endorsed a prospective payment system for hospital outpatient services and, if you have, how quickly do you think it could be implemented?

Mr. POLLACK. No, Mr. Chairman, we haven't endorsed a specific proposal for outpatient prospective payment. We would prefer that the whole issue of reform in the outpatient arena be accomplished within the whole reform of the health care system.

PROPAC has looked at the issue of outpatient payment. They have looked at the APG system, which is currently a prospective payment system for outpatient payment. They are still studying it, and I believe they think that further work needs to be done before they are ready to endorse it. We prefer to see it be done in the context of overall reform.

Mr. WAXMAN. Would you recommend that Medicare continue to recognize residency training costs that vary across hospitals, from $11,000 per resident to more than $100,000, and is it reasonable to assume that training costs should vary this much?

Mr. BENTLEY. Mr. Chairman, in the residency cost there are a series of items involved there. First, the resident stipend and benefits. Second, faculty stipend and benefits. Then, institutional costs.

The institution that reports $11,000, in all likelihood, is not reporting the fulltime resident, even stipend, because those average about $25,000 to $30,000. The institution reporting a cost above $100,000 may be reporting something that the public process should take a look at and determine whether it's reasonable or not.

For example, if you have a primary care program with a small number of trainees but the need to have a program director, program support personnel and faculty, one winds up with a very high cost for resident because of the small number of residents.

Second, one needs to look at how the institution funds its residents. Programs or institutions that have heavy surgical volumes often are able to use the surgeon fees to subsidize the faculty institutions without that opportunity to have that. Similarly, institutions that are large recipients of NIH money may have faculty support that is funded through NIH, that is not available to an institution that has a more primary care emphasis and less to NIH money.

I wouldn't want to categorically, in all honesty, come down on either side of that question. I think it's a question that is a legitimate public debate, but there is a whole series of issues behind that that ought to be looked at and examined individually before any overly simple statement on our part is made.

Mr. WAXMAN. In commenting on the administration's proposal to eliminate the cost differential paid to some hospital based home health agencies, you cited a recent GAO report in support of maintaining the add on. It's my understanding that the GAO also said that the hospital add on may not be necessary to assure beneficiary access to home health services.

I am having a little trouble reconciling these views.

Mr. POLLACK. I think the major point there is that GAO confirmed the fact that the costs in the hospital based home health setting are in fact legitimately higher. Part of the reason that it's higher is that the services provided through those types of programs that are off of the hospital program generally are either broader in scope or they tend to focus on patients that might have more severe conditions, given that they are coming right out of the hospital setting.

It was from that perspective, that we believe that that differential is appropriate.

Mr. WAXMAN. I thank you very much, for your testimony. We appreciate it, and we look forward to working with you.

Mr. POLLACK. Thank you.

Mr. WAXMAN. Our last witness is Mr. Richard Doherty, president of the Comprehensive Home Health Company and vice chairman of the Board of Directors of the National Association of Medical Equipment Suppliers. Mr. Doherty is accompanied by Corrine Parver, president of NAMES. We are pleased to have both of you here before us today. Your prepared statement will be in the record, in full. We would like to ask you to limit the oral presentation to 5 minutes.

STATEMENT OF RICHARD DOHERTY, VICE CHAIRMAN, BOARD OF DIRECTORS, NATIONAL ASSOCIATION OF MEDICAL EQUIPMENT SUPPLIERS, ACCOMPANIED BY CORRINE PARVER, PRESIDENT

Mr. DOHERTY. Thank you, Mr. Chairman. It's a pleasure to have an opportunity to testify before you today. I appear before you today, not only on behalf of Medical Equipment Suppliers across the country, but also to express my personal belief that certain provisions of the administration's fiscal year 1994 budget would erect still further barriers to using home care, at the very time when public policy should be encouraging home medical equipment services and other in home services as a less costly, patient preferred, clinically effective alternative to institutional care.

NAMES members support the overall intent of President Clinton's call to all Americans to help curtail escalating health care costs, and help reduce the staggering Federal deficit. We recognize the paramount necessity of reducing unnecessary or excessive Medicare program costs to help bring Federal spending for health care in check.

In fact, the Medical Equipment Service industry is among the extremely small number of entities that have taken the initiative to work with policy makers to develop responsible solutions to problems within its own industry.

As you may recall, this was clearly evident in the industry's effort during the 102nd Congress to develop a comprehensive home medical equipment ethics bill, H.R. 2534, which helped pave the way for other such bills. Many provisions of H.R. 2534 were included in legislation, later vetoed by President Bush, but have since been reintroduced and are pending before this committee.

The fiscal year 1994 initiatives of President Clinton's economic plan include proposed savings from the medical equipment services industry of $510 million over the next 4 years. This proposal is a frightening addition to reimbursement reductions, totaling $80 million in 1990 and $215 million in 1991.

This disproportionate level of cuts totaling over $800 million are targeted at an industry that accounts for only $1.8 to $2 billion in annual Medicare expenditures, barely 2 percent of the entire Medicare budget.

Of most concern to the medical equipment suppliers are the specific provisions which would adjust fee schedules downward, with an upper limit based upon the median instead of the current methodology using the weighted mean, would grant the Department of Health and Human Services authority to adjust medical equipment rates based totally on as yet undefined market factors, and it would allow Health and Human Services to begin the competitive bidding for home medical equipment services at will.

In respect to competitive bidding, all evidence suggests that it is virtually impossible to design and administer a competitive bidding process without damaging the market, compromising quality and leading to higher prices in the long run. If a winning bid is awarded solely to one provider, this certainly will drive many small companies out of business. The sole winner in future years, thus, would have a considerably reduced level of competition.

With policy makers now considering various mechanisms to reform health care delivery by implementing some type of managed competition it is illogical to create a new scheme at this time just for home medical equipment services that removes the entire concept of competition out of the marketplace all together.

As a supplier who oversees the provision of home medical equipment to Medicare beneficiaries on a daily basis, I urge Congress to remember that the medical equipment services industry already has been singled out among health care providers for an extreme disproportionate level of reimbursement cuts in the past. These reductions have had a harsh impact on the supplier ability to meet the needs of their patients.

In many cases Medicare beneficiaries have been placed in severe jeopardy of losing access to critically important health care services. NAMES recognizes the difficulties faced by Congress and this committee in developing a responsible legislative package that will reduce the Federal deficit, and still address America's critical health care needs.

At the same time, NAMES submits that it is counter productive to enact legislation which does not work to our common goals, of allowing people to be discharged sooner from an institution and permitting people with severe disabilities to lead productive lives. Such obviously cost effective and compassionate means of providing health care in the home should be encouraged and fostered where possible where clinically appropriate.

The home medical equipment service industry, a valuable element in our Nation's health care system, helps make homecomings possible for many sick and elderly Americans. Home medical equipment suppliers are willing to do their part to assist the administration and Congress in reducing Medicare expenditures, but the budget cannot be balanced on the backs of this industry through repetitive consideration of ill thought out proposals that have been rejected time and time again.

Again, Mr. Chairman, thank you for an opportunity to testify. I am happy to answer any questions.

[The prepared statement of Mr. Doherty follows:]

NAMES
National Association of
Medical Equipment Suppliers

TESTIMONY
OF
RICHARD DOHERTY,
PRESIDENT, COMPREHENSIVE HOME HEALTH COMPANY,
AND
REPRESENTING
THE NATIONAL ASSOCIATION OF MEDICAL EQUIPMENT SUPPLIERS
ON THE
ADMINISTRATION'S FY 1994 MEDICARE BUDGET
BEFORE THE
SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT
HOUSE ENERGY AND COMMERCE COMMITTEE
HEARING
OF
MARCH 31, 1993

Mr. Chairman and Members of the Committee: I am pleased to testify before you today. My name is Rick Doherty. My company, Comprehensive Home Health Company in Avon, MA, serves the metropolitan Boston area. I have 13 years experience as a supplier of home medical equipment (HME) services.

I currently serve as Vice Chair on the Board of Directors of the National Association for Medical Equipment Suppliers (NAMES), the national trade association representing the HME services industry exclusively. Thus, I appear before you today not only on behalf of HME suppliers across the country, but also to express my personal belief that certain provisions of the Administration's fiscal year 1994 (FY 94) budget would erect still further barriers to using home care at the very time when public policy should be encouraging home medical equipment (HME) services and other in-home services as a less costly, patient preferred and clinically effective alternative to institutional care.

Many of you are by now aware of the tremendous range of products and services provided by HME suppliers. They range from so-called "standard" HME items such as hospital beds and walkers, to highly sophisticated services such as oxygen ventilators and concentrators; parenteral and enteral nutrition; antibiotic, chemotherapy and other drug therapies administered intravenously; and specialized rehabilitation equipment customized for the unique needs of persons with disabilities and fitted by rehab technology suppliers (RTS).

NAMES members support the overall intent of President Clinton's call to all Americans to help curtail escalating health care costs and help reduce the staggering Federal deficit. We recognize the paramount necessity of reducing unnecessary or excessive Medicare program costs to help bring federal spending for health care in check. In fact, the HME services industry is among the extremely small number of entities that have taken the initiative to work with policymakers to develop responsible solutions to problems within its own industry. As you may recall, this was clearly evident in the industry's efforts during the 102nd Congress to develop a comprehensive HME ethics bill, H.R. 2534, which helped "pave the way" for the myriad other such bills with similar intent. Many provisions of H.R. 2534 were included in legislation vetoed later by President Bush (H.R. 11), but have since been reintroduced (H.R. 21 and 22) and are pending before this Committee.

The FY 94 initiatives in President Clinton's Economic Plan include proposed savings from the HME services industry of $510 million over the next four years. This proposal is in frightening addition to reimbursement reductions totaling $80 million in 1990 and $215 million in 1991. This disproportionate level of cuts, totaling over $800 million, are targeted at an industry that accounts for only $1.8-$2.0 billion in annual Medicare expenditures, barely two percent of the entire Medicare budget!

Of most concern to HME suppliers are the specific provisions which would:

- Adjust HME fee schedules downward with an upper limit based upon the median, instead of the current methodology using the weighted mean;
- Grant the Department of Health and Human Services (HHS) authority to adjust HME rates based on totally undefined "market factors"; and
- Allow HHS to begin competitive bidding for HME services at will.

I would like to elaborate on the reasons why the HME services industry cannot support these specific provisions. Of paramount concern is the Administration's proposal to allow competitive bidding for HME and related services. This demonstrates once again that the bureaucracy often fails to learn from its past, well-publicized mistakes. As reported in *The Washington Post*, competitive bidding in the Department of Defense has entailed volumes of product specifications, a hugh bureaucracy and a glacial pace of operations. As for cost-containment, it is a joke, a scandal, or both, depending on one's point of view.

Similarly, Congress should be concerned that the service component, so integral to ensuring patient health and safety when providing needed equipment, may diminish or disappear. For example, the Joint Commission on Accreditation of Health Care Organizations (JCAHO) and others have documented deficiencies and a poor quality of HME services provided by many winning bidders under the VA's competitive bidding process. Congress should anticipate even greater problems if competitive bidding were applied under Medicare.

Unlike the VA, which is a self-contained program serving a relatively small number of patients, Medicare covers vast numbers of the elderly and disabled throughout the entire nation and often living in areas difficult to access. Local suppliers are committed to their service area and make the extra efforts necessary to serve these patients. A remote supplier chosen on the basis of lowest bid will not have the commitment. Moreover, review of signed "low bid" contracts across the Southeast and Southwest VA systems have revealed additional charges, passing outside the bid price and which increase costs without addressing the problems of quality and accessibility.

Congress also should consider the fact that competitive bidding for certain selected HME items under Medicaid has been tried previously and subsequently abandoned in a number of states for a variety of reasons similar to which Medicare would experience. There are enormous complexities involved in dividing the entire nation into multiple and reasonable service areas. Few suppliers provide all possible HME services and therefore it would be necessary to define different service areas and winning bidders for different kinds of equipment. Currently, it takes on average 90 days for HME suppliers to get paid; as a result, it is highly likely that only a few companies would have the capital necessary to expand into new services in order to take on large competitively bid contracts. This could easily lead to concentrations of Medicare's entire HME benefit in the hands of a relatively few suppliers.

In short, all evidence suggests it is virtually impossible to design and administer a competitive bidding process without damaging the market, compromising quality and leading to higher prices in the long run. If a winning bid is awarded solely to one provider, this certainly will drive many small companies out of business; the sole winner in future years thus would have a considerably reduced level of competition. With policymakers now considering various mechanisms to reform health care delivery by implementing some type of "managed competition," it is illogical to create a new scheme at this time just for HME services that removes the entire concept of competition out of the marketplace altogether!

HCFA currently is in the process of implementing a significant change in claims processing for HME, whereby the number of Medicare carriers which currently process HME claims will be reduced from 34 to just four "regional carriers." These four carriers will be charged with processing all claims for HME, parenteral and enteral nutrition, and orthotics and prosthetics. In light of the tremendous business operational changes this new government-imposed system will bring, it is unreasonable to expect either HME suppliers or the four new carriers to assume and carry out successfully the myriad complexities involved in administering competitive bidding. For these reasons, we urge you to reject outright any proposal that would permit competitive bidding for HME at this time.

The HME services industry also is concerned with the Administration's proposal to set HME payments at the national median. As you may recall, in OBRA 1987 Congress abolished payment for HME according to the original reasonable charge methodology and substituted regional fee schedules in its stead. In OBRA 1990, Congress eliminated regional pricing in favor of a phased-in national fee schedule. Because of the disparities and numerous flaws in the Health Care Financing Administration (HCFA) data used to calculate HME fees originally, Congress rightly viewed that the only equitable mechanism to calculate the new national fees was according to the **weighted mean.**

We are now in the last year of phasing-in to the national fee. Virtually all major pricing disparities between Medicare payment amounts in various states have now disappeared. To impose yet another change and administrative burden on carriers and HME suppliers alike at this time by again revising a national payment rate at the median for all HME items would mean going back into the old, flawed data base — a proposition Congress already rejected and, we believe, should not revisit.

The President's FY 94 budget also would empower HHS and HCFA to make payment determinations based solely on undefined "market factors." This would allow HCFA to impose virtually any proposal to reduce funding for HME, including many that Congress already has considered and refused to enact in prior years — without the benefit of debate and discussion in a Congressional forum. This proposal, originally advanced by the previous Administration, was rejected outright by Congress in the past — Members quite rightly viewed the absolute delegation of *carte blanche* authority to HCFA to set Medicare reimbursement for HME at-will in the future as an improper delegation of legislative authority. We urge you again to continue to reject this unwise proposal.

As a supplier who oversees the provision of HME to countless of Medicare beneficiaries on a daily basis, I urge you to remember that the HME services industry already has been singled out among health care providers for an extreme, disproportionate level of reimbursement cuts in the past. These reductions have had a harsh impact on suppliers' ability to meet the needs of their patients. In some instances, HME companies either have been forced to close altogether or, at a minimum, to redefine their service capabilities, particularly in rural areas. In such cases, Medicare beneficiaries have been placed in severe jeopardy of losing access to critically important health care services.

In closing, NAMES recognizes the difficulties faced by Congress and this Committee in developing a responsible legislative package that will reduce the Federal deficit and still address America's critical health care needs. At the same time, NAMES submits that it is counterproductive to enact legislation which does not work to our common goals of allowing people to be discharged sooner from an institution and permitting people with severe disabilities to lead productive lives. Such obviously cost-effective and compassionate means of providing health care in the home should be encouraged and fostered where possible and clinically appropriate.

HME suppliers do much more than just deliver home medical equipment to Medicare beneficiaries and others — they work intensively with physicians, discharge planners, nurses, therapists and other health care professionals as necessary to select appropriate equipment; set up the equipment and educate patients and their caregivers on how to use the equipment properly; service the equipment 24 hours a day, every day; undergo rigorous disinfection processes when equipment is retrieved; and complete expensive, ever-increasing Medicare paperwork for their patients. This high level of home care services must be encouraged — not destroyed.

The HME services industry, a valuable element in our nation's health care system, helps make homecomings possible for many sick and elderly Americans. HME suppliers are willing to do their part to assist the Administration and Congress in reducing Medicare expenditures, but the budget cannot be balanced on the backs of this industry through repetitive consideration of ill-thought out proposals that have been rejected time and time again.

I will be pleased to answer any questions you may have. Thank you for allowing me to testify.

Mr. WAXMAN. Thank you, very much. Last year this committee reported out a series of Medicare DME amendments that were incorporated into H.R. 11, which passed the Congress but which was vetoed by President Bush. Some of the provisions in that legislation deal with the use of an inherent reasonableness standard and with other payment policies.

Does NAMES have a position on the DME provisions included in H.R. 11, some of which I believe are in the administration's budget this year?

Ms. PARVER. Many of the provisions that were included in H.R. 11 were in Ben Cardin's bill, H.R. 2534, and they had strong support from the medical equipment industry. Other provisions introduced by Representative Pickle concerning abuse of telemarketing practices, are fully supported as a way for the industry to police itself and help curb fraud and abuse.

We were fully supportive of the provisions that were in H.R. 11, that President Bush vetoed, that also were in H.R. 2534. As far as the inherent reasonableness standard, OBRA 87 revised the methodology for reimbursement for home medical equipment services. In that legislation which you helped co-author, was a ban on inherent reasonableness authority for HHS while this new payment system was being instituted. In some respects, the industry would prefer keeping the ban at the present time.

Mr. WAXMAN. In light of the consolidation of Medicare carriers for DME claim, do you believe that we will be able to fairly compare the prices paid for covered items and thus narrow what appear to be wide variations in the payments for the same or similar items?

Mr. DOHERTY. Yes, Mr. Chairman. I think with the implementation of the four regional carriers, once it is fully implemented, that the differentiation in pricing around the country will be greatly reduced.

Mr. WAXMAN. I appreciate very much your being here today and giving us your testimony. We will look forward to working with you on this whole problem.

That concludes our hearing for today. We stand adjourned.

[Whereupon, at 1:03 p.m., the subcommittee adjourned, to reconvene tomorrow, April 1, 1993.]

[The following material was submitted for the record by Hon. J. Roy Rowland:]

STATEMENT

# of the

AMERICAN ASSOCIATION OF NURSE ANESTHETISTS

The American Association of Nurse Anesthetists (AANA) is the professional association that represents over 25,000 certified registered nurse anesthetists (CRNAs), which is more than 96 percent of the nurse anesthetists in the United States. For those new members of the committee who may be unfamiliar with CRNA practice, we will provide some background information for you in an attachment to this testimony.

The AANA appreciates the opportunity to provide testimony regarding the Administration's Fiscal Year 1994 budget proposal to bundle payments for inpatient radiology, anesthesiology, and pathology services into a hospital DRG payment (a RAP DRG).

AANA SUPPORTS ANESTHESIA REFORM BUT OPPOSES A RAP DRG

The AANA supports the need for health care reform in this country, due to skyrocketing health care costs and lack of access to health care by millions of Americans. We believe that anesthesia providers must do our part in terms of helping to reform inefficiencies in the anesthesia system that result in unnecessarily high federal expenditures. But the AANA opposes the Administration's RAP DRG proposal because its methodology does not appropriately address the role that CRNAs play in providing patients access to safe, cost-effective anesthesia services. The proposal ignores the fact that since 1989, CRNAs have the authority to be paid directly under Medicare Part B. The proposal only mentions medical staff and individual physicians.

CRNA PRACTICE ARRANGEMENTS

The 1992 AANA Membership Survey data indicates that approximately 42% of CRNAs are employed by a hospital, 33% are employed by a CRNA/anesthesiologist group, and 15% are self-employed, work for CRNA groups, or work as locum tenens (providing vacation/temporary relief). The remainder work in offices, clinics, surgicenters, universities, the military, the Veterans Administration, or the U.S. Public Health Service. AANA has historically believed that the marketplace should decide what CRNA/anesthesiologist practice arrangements should be.

The Administration's RAP DRG payment would be made to the medical staff, or to the hospital if the medical staff did not want to receive the payment. AANA's reason for opposing the proposal can be graphically depicted by the following possible scenario: a hospital contracts out for radiology and pathology services from a radiology/pathology group, but employs CRNAs to provide anesthesia services. Under the Administration's proposal, the radiology/pathology group could receive the Medicare RAP DRG payment and then the hospital would be required to negotiate with that group for its portion of the payment for CRNA services. The AANA does not believe that hospitals should be placed in the position of having to negotiate with a radiology/pathology group to receive its appropriate share of payment for the services of its CRNA employees.

SUMMARY

The AANA believes that there must be reform in anesthesia payment under Medicare. However, the AANA opposes the Administration's RAP DRG proposal because its methodology does not appropriately address the role that CRNAs play in providing patients access to safe, cost-effective anesthesia services.

The AANA appreciates the support that this committee has historically shown for the value of CRNA services. Thank you for your consideration of our views on this issue. We request the opportunity to orally testify on any additional proposals for anesthesia payment reform that may come before the committee during this congressional session.

BACKGROUND ON CRNA PRACTICE

This attachment provides background information for you on the following CRNA issues:

1. History of nurse anesthesia,
2. Educational preparation,
3. Patient access,
4. Quality of care,
5. Cost-effectiveness of care,
6. Physician liability,
7. Clinical privileges,
8. History of Medicare anesthesia payment, and
9. CRNA Medicare rates.

History of Nurse Anesthesia

Nurses have been providing anesthesia services to patients within the U.S. since the late 1870's. Because there had been significant morbidity and mortality associated with the use of the "occasional anesthetist" for the administration of anesthesia, surgeons in the U.S. encouraged nurses to specialize in this field. At first, most nurse anesthetists learned their anesthesia in on-the-job training programs (similar to medical residencies of that day). The educational preparation and practice of CRNAs is quite different today.

Educational Preparation

There are currently 92 accredited nurse anesthesia education programs. The requirements for admission to a nurse anesthesia education program are:

- A Bachelor of Science in Nursing or another appropriate baccalaureate degree,
- A license as a registered nurse, and
- A minimum of one year of acute care nursing experience.

Nurse anesthesia education programs comprise 24-36 months of graduate course work including both classroom and clinical experience. The classroom curriculum emphasizes anatomy, physiology, pathophysiology, biochemistry, chemistry, physics and pharmacology as they relate to anesthesia. The major clinical component provides experience with a variety of anesthesia techniques and procedures for all types of surgery and obstetrics. Of the 92 nurse anesthesia education programs, 80% offer a master's degree. The other 20% of programs are modifying their curriculum to meet the requirement that all programs offer a master's degree beginning in 1998.

Patient Access Increased

CRNAs increase access to anesthesia services, by administering 65% of the 26 million anesthetics given in the United States annually. CRNAs are the sole anesthesia providers in 85% of rural hospitals. CRNAs provide anesthesia services for all types of surgeries, in all types of facilities, and for all levels of patient acuity.

Quality of Care Provided by CRNAs

CRNAs have the legal authority to practice anesthesia in all 50 states, without anesthesiologist supervision. There is no study which shows that the anesthesia care provided by an anesthesiologist is superior to that provided by a CRNA. In fact, the only studies that exist suggest that the quality of care is not significantly different.

The practice of anesthesia has gotten safer in recent years due to improvements in medications and technology advances that allow for increased patient monitoring. In fact, in 1990 the Centers for Disease Control (CDC) decided not to conduct a national multi-million dollar morbidity and mortality study on anesthesia. Doug Klauke, MD, Assistant Director for Science, Division of Surveillance and Epidemiologic Studies, Epidemiology Program Office, CDC, publicly stated that "the expected benefit of this multi-million study is clearly not justified."

Cost-effectiveness of CRNA Practice

A 1990 Department of Health and Human Services report presented the results of a study of nurse anesthesia manpower needs by the Health Economics Research, Inc. It estimated that the cost of delivering anesthesia services in a model that underutilizes CRNAs and overutilizes anesthesiologists will be $1.2 billion more in 2010 than it would be under a more efficient model.

CRNAs have accepted mandatory assignment under Medicare. Anesthesiologists can balance bill Medicare beneficiaries. In 1992, only 49.3% of anesthesiologists were participating physicians.

Physician Liability

A physician or authorized provider is not automatically liable when working with a CRNA, nor is the physician immune from liability when working with an anesthesiologist. In Schneider v. Einstein Medical Center, 390 A.2d 1271 (Penn. 1978) and Kitto v. Gilbert, 570 P.2d 544 (Colo. 1977), the court found the physicians liable for the negligence of anesthesiologists because the physicians were in control of the anesthesiologist's actions. The question, as in the case of a physician working with CRNAs, is whether the physician was in control of the acts of the anesthesiologists. Usually, this is a factual inquiry, and not a conclusion of law. There are many cases in which the courts have found that the surgeon was not in control of the CRNA and, therefore, not liable for the negligence of the CRNA. Cavero v. Franklin Benevolence Society (223 P. 2d 471, California, 1950), Fortson v. McNamara (508 So. 2d 35, Florida, 1987), Hughes v. St. Paul Fire and Marine Insurance Company (401 So. 2d 448, Louisiana, 1981), Kemalyan v. Henderson (227 P. 2d 372, Washington, 1954), Parks v. Perry (68 N.C. App. 22, North Carolina, 1984), Sesselman v. Mulenberg Hospital (306 A.2d 474, New Jersey, 1954). Numerous cases hold that mere supervision or direction of a CRNA is insufficient evidence to hold a physician liable for the CRNA's negligence. See, for example, Baird v. Sickler, 69 Ohio St.2d 652 (1982); McCullough v. Bethany Medical Center, 235 Kan. 732 (1984); Elizondo v. Tavarez, 596 S.W. 2d 667 (Texas, 1980); Parker v. Vanderbilt, 767 S.W. 2d 412 (Tenn., 1988); Whitfield v. Whittaker Memorial Hospital, 210 Va. 176 (1969). It is clear from the case law that in order for a physician to be liable for the acts of the anesthesia administrator, the physician must be in control of the administrator's actions and not merely be supervising or directing the administrator.

There is no greater liability when surgeons or obstetricians work with CRNAs. The principles governing liability of a surgeon when working with a CRNA are the same as those governing the liability of a surgeon when working with an anesthesiologist. The courts do not look at the status of the anesthesia administrator but, in most states, at the degree of control the physician exercises over the administrator - whether that administrator is a CRNA or an anesthesiologist. The issue in each case is the extent to which the physician has control over the anesthesia administrator. Thus, a court may render different conclusions for cases that involve a physician working with a CRNA - or, for that matter, a physician working with an anesthesiologist - if the physician controlled the CRNA in one case but not in another. Every state permits CRNAs to work without anesthesiologist supervision. Some state licensing laws require that CRNAs work under the "supervision" or "direction" of a physician. Such "supervision" or "direction" does not require that the CRNA be supervised by an anesthesiologist. The Joint Commission on Accreditation of Healthcare Organizations does not require that CRNAs be supervised by an anesthesiologist.

The nature of anesthesia requires the constant vigilance of the anesthesia provider. Studies of anesthesia related incidents show that most are avoidable. Most mishaps result from a failure of the practitioner to vigilently monitor the patient, not from lack of education. Vigilance has been the hallmark of nurse anesthesia education since the profession's creation. The AANA has been publishing standards calling for increased monitoring since 1974. In 1986, after publication of studies of anesthesia related incidents showed that most could have been avoided, the HARVARD MINIMAL MONITORING STANDARDS ON ANESTHESIA CARE were published in the Journal of the American Medical Association (the AANA was the first organization to endorse the then controversial Harvard Standards). Since then, the AANA has issued even more explicit monitoring standards.

The most substantial difference between CRNAs and anesthesiologists is that prior to anesthesia education, anesthesiologists first receive medical education while CRNAs first receive nursing education. However, the anesthesia part of the education is very similar for both providers. CRNAs and anesthesiologists are both educated to use the same anesthesia process in the provision of anesthesia and related services.

Regarding malpractice insurance, St. Paul Fire and Marine Insurance Company has been the underwriter for the AANA's Professional Liability Insurance Program for more than eight years. St. Paul, the largest medical malpractice underwriter in the United States, bases their yearly professional insurance premium for CRNAs on previous claim losses. For the last three years, there has been an average annual decrease of 6% in CRNA professional liability insurance premiums due to the decreased number of claim losses.

Clinical Privileges

If there is insufficient reimbursement for medically directed CRNA services, then hospitals or anesthesiologist groups may no longer want to employ CRNAs. As a result, CRNAs may be forced to become independent practitioners and compete with anesthesiologists. However, there is not always an equal opportunity to compete. CRNAs are required in most hospitals to practice under a clinical privileging process. But it is sometimes difficult for CRNAs to secure hospital/facility clinical privileges due to exclusive contracts and restrictive medical staff bylaws which either prohibit or deter applications based on the class of provider, or require recommendation and/or approval by the Physician Chief of the Anesthesiology Department. These factors are often difficult to surmount because CRNAs with hospital/facility clinical privileges may be viewed as competitors of the anesthesiologists on staff at the hospital/facility. Consequently, the AANA urges Congress to mandate an open and equitable privileging process in all health care facilities receiving federal funding, which would allow access to all classes of providers.

History of Medicare Anesthesia Reimbursement

The issue of how to pay for anesthesia services when provided by CRNAs and anesthesiologists working together is not new. It is something that Congress, the Health Care Financing Administration (HCFA), and professional anesthesia associations have struggled with since the inception of Medicare in 1965. The following is a brief historical perspective on anesthesia reimbursement under Medicare.

1. As enacted in 1965, Medicare (Title XVIII of the Social Security Act) reimbursed hospitals under Part A for "reasonable costs" of anesthesia services provided by hospital-employed CRNAs. Anesthesiologists who employed and supervised CRNAs could bill under Part B as if they personally performed the case. Anesthesiologists who supervised CRNAs who were employed by a hospital could bill the same base units as if they did the case themselves, but their time units were halved.

2. The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) established conditions that anesthesiologists must fulfill in order to be paid for medically directing CRNAs. In addition, TEFRA limited to four the number of concurrent cases of medically directing CRNAs that an anesthesiologist could be reimbursed for.

3. The Social Security Amendments of 1983 created the Prospective Payment System (PPS). Under PPS, all hospital Part A payments were bundled into diagnosis-related groupings (DRGs). Hospitals would have been forced to pay for their CRNA employee costs out of the fixed DRG payments which they would receive. However, the CRNA costs included within the global DRGs had been very undervalued. Therefore, hospitals could not have recouped their actual CRNA costs through Medicare payments. This created a disincentive for hospitals to employ CRNAs. In addition, PPS precluded the unbundling of services. Therefore, anesthesiologists who employed CRNAs that worked in a hospital would have been forced to contract with that hospital to get the CRNA portion of the DRG.

4. The Deficit Reduction Act of 1984 established a pass-through provision for hospital-employed CRNA costs for a three-year period, assuring hospitals that they would not lose money by employing CRNAs. It also allowed an exception to the unbundling provisions in PPS, to accommodate anesthesiologists billing for their CRNA employees. However, due to the temporary nature of the pass-through provision, AANA immediately sought a legislative remedy that would provide for direct CRNA Medicare reimbursement.

5. The Omnibus Budget Reconciliation Act of 1986 (OBRA86) established direct reimbursement for CRNAs under Medicare Part B, effective on January 1, 1989. It also continued the existing forms of hospital and anesthesiologist billing for CRNA services under Medicare until December 31, 1988.

6. The Omnibus Budget Reconciliation Act of 1987 imposed reductions in base units for anesthesiologists who medically directed CRNAs. Anesthesiologists' base units were reduced by 10% when medically directing CRNAs in two concurrent procedures, 25% for three procedures, and 40% for four procedures.

7. The Omnibus Budget Reconciliation Act of 1989 created the resource-based relative value scale (RBRVS) system. During the implementation of RBRVS, the services of anesthesiologists were found to be 29% overvalued, not 18%, as had been originally estimated.

8. The Omnibus Budget Reconciliation Act of 1990 (OBRA90) statutorily established higher Medicare conversion factors for CRNAs. It is noteworthy that Congress did not view CRNA fees as overvalued, on the contrary, it increased CRNA conversion factors just a year after decreasing anesthesiologist conversion factors. OBRA90 also extended the 10%, 25%, and 40% reduction in base units for the concurrent medical direction of two, three, and four CRNAs respectively, until December 31, 1995. In addition, it reduced the weighted national average conversion factor for anesthesiology services by 7% in 1991, adjusted by geographic indices.

9. Under the RBRVS phase-in, 1992 payments per service for anesthesiologists were reduced on average by 11%.

Increased CRNA Medicare Rates Needed to Provide Equity

CRNA Medicare conversion factors have risen in recent years to correct a huge inequity in the CRNA conversion factors that HCFA established under the CRNA direct reimbursement law. OBRA86 directed HCFA to develop a CRNA fee schedule under which total payments for CRNA services would equal the estimated total amounts that would have been paid in 1989, if the services were included as inpatient hospitals services. In January 1989, HCFA published an interim CRNA fee schedule that was 35% below what would have been paid under a continued Medicare Part A pass-through.

HCFA's low CRNA conversion factors occurred for two reasons. First, there was a technical error in the fee schedule legislation. A two-step budget neutrality requirement forced HCFA to calculate the CRNA conversion factors using only the monies paid for CRNA services under Part A (which represented only 65% of the total CRNA costs). Left out of the equation were the other 35% of costs of CRNAs who were physician-employed. Therefore, the interim CRNA fee schedule attempted to pay 100% of CRNAs with only 65% of the money that had paid out for CRNA services in the previous year. Second, HCFA admittedly undervalued CRNA services by not using the most current and accurate AANA data. This undervaluing problem was eventually corrected in the CRNA final fee schedule published on July 31, 1992, and financial corrections were made by HCFA. However, the only way to remedy the technical error in OBRA86 regarding physician-employed CRNA costs, that resulted in inequities in the 1989 interim fee schedule, was for AANA to return to the legislative arena to secure fair Medicare CRNA conversion factors.

When HCFA was developing the 1989 CRNA conversion factors, AANA had repeatedly contended that the average amount per unit that would have been paid under a cost-based system in 1989 for a non-medically directed CRNA was $21.83; the average amount per unit for a medically directed CRNA was $13.85. These $21.83 and $13.85 figures were the basis for the legislation in the 102nd Congress which sought a $21.00 conversion factor for non-medically directed CRNAs and a $14.00 conversion factor for medically directed CRNAs. AANA contended that the $21/$14 fee schedule would more fairly approximate what Medicare would have paid in 1989 if the CRNA Medicare direct reimbursement hadn't been enacted.

Congress agreed with AANA on the need to increase CRNA conversion factors. OBRA90 included statutorily-determined Medicare CRNA conversion factors, effective January 1, 1991. (See Appendix 7) While the original AANA-supported legislation in the 102nd Congress would have created a national Medicare CRNA payment rate of $21 per unit for non-medically directed CRNAs and a $14 per unit for medically directed CRNAs, our efforts were stymied by the severe budget deficit facing the nation. Congress was only willing to accept a fee schedule proposal that would reimburse non-medically directed CRNAs at the same level that anesthesiologists would be in 1996, at the end of the RBRVS transition. At that time, anesthesiologist services were estimated to be, on average, 18% overvalued. It was envisioned that the 1990 anesthesiologist average conversion factor of $20.42 would be gradually decreased under RBRVS until in 1996 it would reach 82% of $20.42, which is $16.75.

Non-medically Directed CRNA Rates

Therefore, the non-medically directed CRNA conversion factors were set to begin in 1991 at $15.50 and increase $0.25 per year until they reached $16.75 in 1996 (adjusted by geographic indices). The $16.75 is the same rate that anesthesiologists were predicted to receive in 1996.

1991 - $15.50
1992 - $15.75
1993 - $16.00
1994 - $16.25
1995 - $16.50
1996 - $16.75

Medically Directed CRNA Rates

The medically directed CRNA conversion factors were set at 70% of the non-medically directed CRNA conversion factors. Therefore, they would begin in 1991 at $10.50 and increase $0.25 per year until they reached $11.70 in 1996 (adjusted by geographic indices).

1991 - $10.50
1992 - $10.75
1993 - $11.00
1994 - $11.25
1995 - $11.50
1996 - $11.70

When the CRNA rates under OBRA90 were created, no one envisioned that anesthesiologist services would eventually be viewed as 29% overvalued under RBRVS. The fact that anesthesiologist services were ultimately viewed as 29% overvalued, versus 18% as originally projected, is the reason that anesthesiologist conversion factors have declined so dramatically in recent years.

The fact that anesthesiologist rates have declined, however, does not diminish the fact that the CRNA increases under Medicare are justified by the fact that they are not higher than they would have been if CRNA services were still paid for under the hospital reasonable cost pass-through. Any attempt to utilize a snapshot of CRNA Medicare conversion factors for 1990-1992 as a way of legitimizing future CRNA payment cuts is a misrepresentation of the history of CRNA payment under Medicare. The higher OBRA90 CRNA conversion factors merely brought equity to CRNA Medicare payment, which had been underpaid since 1989.

The AANA fought very hard to secure fair direct CRNA reimbursement under Medicare. We have also consistently urged the Physician Payment Review Commission and Congress to establish a payment policy that determines the value of an anesthesia service and then pays that amount to whoever provides the service.

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STATEMENT OF THE AMERICAN CLINICAL LABORATORY ASSOCIATION BEFORE THE HOUSE ENERGY & COMMERCE COMMITTEE

March 31, 1993

The American Clinical Laboratory Association ("ACLA") is pleased to have this opportunity to comment on the Administration's budget proposals affecting reimbursement for clinical laboratory testing. ACLA is a trade association of federally regulated, independent clinical laboratories. ACLA represents national, regional, and local laboratories located throughout the United States. ACLA members will be significantly affected by the Administration's proposals for laboratories.

In the budget submitted to Congress, the new Administration has proposed reducing the national limitation amounts for laboratories from their current level of 88 percent of the fee schedule medians, to 76 percent of the medians. Further, the Administration has proposed limiting the update in the fee schedules to 2 percent, rather than raising them by the increase in the CPI, as was originally contemplated when the fee schedules were established. The update was set at 2 percent by OBRA'90 for 1991 through 1993, after which time it was to return to the full amount of the CPI. *See* §1833(h)(2)(A)(ii). Finally, the Administration has suggested allowing the Secretary of HHS to adjust Medicare payment rates to laboratories "to account for technological changes or other market factors."

For many years, ACLA has appeared before this Subcommittee to offer our views and our cooperation on ways to lower the federal deficit through equitable reductions in Medicare outlays for laboratory testing. In 1984, we assisted in the development of the Medicare fee schedule, which substantially reduced the amounts that Medicare paid to laboratories. In 1987, 1989, and 1990, we worked with Congress in suggesting other savings that could be achieved by lowering the national limitation amounts. As a result of the budget agreement reached in 1990, a proposal that ACLA supported, clinical laboratories will absorb additional cuts of $1.2 billion between 1991 and 1996.[1]

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[1] Committee on Ways and Means, *Overview of Entitlement Programs* ("*The Green Book*") at 209 (1991).

ACLA has always participated in this process because we recognize our responsibility to help reduce the federal budget deficit. In addition, like other providers, we also recognize the need to assist in the on-going effort to reform the health care system. Thus, this year, we believe it is necessary to discuss not just our response to the new Administration's proposed reductions in laboratory reimbursement, but also our views on how laboratory services should be treated under health care reform. As discussed below, these two issues are inextricably linked, for ACLA can accept additional cuts in Medicare reimbursement, but only if the fundamental structural problems plaguing the laboratory market are corrected as part of health care reform.

In the past, ACLA has urged that changes be instituted in the industry through passage of a federal direct billing law, which would require that laboratories that perform testing bill the appropriate payor for that work. In view of the new cuts proposed by the Administration and the efforts to reform health care generally, it is imperative that direct billing now become a reality. Direct billing will result in a more efficient laboratory market that will ultimately benefit all payors, including Medicare. Further, an independent study discussed below shows that enactment of direct billing could reduce non-Medicare health care costs generally by between $2.4 and $3.2 billion a year. Such reductions are urgently needed to help fund other health care reforms. If direct billing is enacted, ACLA members would be better able to absorb the cuts in reimbursement that are being proposed. In addition, the enactment of direct billing would also allow laboratories to absorb reductions in reimbursement received from private payors, as detailed in the attached health reform proposal. (See Appendix 1.) Without the enactment of direct billing, additional Medicare cuts will simply force many laboratories to reduce services and could force some laboratories to close entirely, thereby reducing access to testing services.

In our testimony today, we would first like to give some information on the background of laboratory reimbursement and the need for change. Then, we will address the Administration's current proposals and detail our proposal for reform.

1. The Value of Laboratory Testing.

Laboratory testing is an important, life-saving and cost-containing health care tool, which permits the early detection and treatment of a variety of conditions. Laboratory testing is instrumental in the early diagnosis of diseases such as AIDS, Hepatitis and countless others. Other tests, such as therapeutic drug monitoring ("TDM") assays, are used routinely to track the effects of life-saving medications prescribed for cancer and other serious illnesses. Concern about coronary heart disease has caused an increased awareness of the need to perform regular cholesterol testing and related measurements of HDL and LDL. The early diagnosis and treatment permitted by appropriate testing ultimately saves money for all health care payors, including Medicare. Indeed, the greatest value of clinical laboratory testing is its ability to lead to the early diagnosis of disease and to prompt, cost-effective treatment.

Since 1984, laboratories, like many providers, have repeatedly had to confront reduced Medicare reimbursement. The caps on the fee schedules, which were initially set at 115 percent of the fee schedule medians, were subsequently reduced to 100 percent in 1988; to 93 percent in 1990; and then to 88 percent in 1991. At the same time, there have also been reductions in the CPI updates and freezes on other payments.

Appendix 2, which is attached to this testimony, shows the impact of these repeated reductions in reimbursement for clinical laboratory services. The five different budget bills enacted between 1984 and 1990 slashed clinical laboratory reimbursement by an estimated $3.5 billion. According to the most recent information, the Administration's latest budget request would impose an additional $2.8 billion in cuts over the next five years.

At the same time, the costs of laboratory testing have increased substantially. For example, as a result of the emergence of AIDS and Hepatitis B, laboratories now take additional precautions to protect workers from bloodborne pathogens, as required by the Occupational Safety and Health Administration, including paying for workers' vaccinations. In addition, the new requirements imposed by the Clinical Laboratory Improvement Amendments of 1988 ("CLIA'88") and other regulations, such as those related to medical waste removal and treatment, have further added to laboratory expenditures. ACLA does not argue with the need to protect workers, safeguard quality control or protect the public health and our environment; nonetheless, implementing these requirements is expensive.

In addition, laboratory labor costs have also dramatically increased over the past five years. For example, a recent report by the American Society of Clinical Pathologists ("ASCP") shows that salaries for phlebotomists, the individuals who draw blood, have risen by almost 20 percent since 1990. Cytologist salaries grew by 17.4 percent for staff level positions and 14.4 percent for supervisory positions during that same period.

Such increasing costs, when coupled with further reductions in reimbursement, cannot help but affect the ability of laboratories to offer accessible, efficient, high quality laboratory testing.

2. The Need for Structural Change

In view of these increasing costs and reductions in reimbursement, laboratories are hesitant to agree readily to additional cuts in Medicare rates. However, ACLA could accept some cuts, if Congress also enacted other changes in the market. Enactment of a direct billing law would permit laboratories to accept such reductions, because it would result in a more equitable payment structure and, in addition, would ultimately save money for the entire health care system.

To understand the importance of direct billing, it is important to understand how the laboratory market works. Under the present system, physicians can request that laboratories bill them for testing that they order for their non-Medicare patients. Because laboratories cannot order testing themselves, the physician can also request--and receive--discounts from the laboratory providing this testing. The physician can then mark-up these tests when third parties and patients are billed. This system gives the doctor a financial interest in the testing that is ordered, comparable to that which exists in the case of self-referral. As a result, the current system creates incentives that can lead to increased use of laboratory testing. Because of the obvious concerns arising from this arrangement, Medicare requires the laboratory performing the testing to bill the Program directly. Most states, however, permit the laboratory to bill the physician for non-Medicare testing.

The current system results in cost-shifting because it forces laboratories to increase prices to other payors--to Medicare, to the extent possible, to third-party payors and to patients. Medicare has protected itself from such shifting to some extent through the enactment of the fee schedules and national limitation amounts. However, patients and private payors still end up paying increased prices, either because they bear the mark-up tacked on by the test-orderer or because laboratories are forced to offset physician discounts and reductions in Medicare reimbursement when they bill patients and third-party payors.

Reform of this system would allow laboratories to absorb the lower Medicare reimbursement proposed by the Administration because it would eliminate the inequities noted above. Under such a system, the laboratory that performed the testing would usually be required to bill for the testing. Enactment of such a provision would eliminate the incentives that currently lead to increased testing. Furthermore, because laboratories would no longer have to offset the discounts given to test-orderers, laboratories could afford to accept lower reimbursement from Medicare, private payors and patients.

In addition, the enactment of direct billing would result in a substantial savings to the health care system. An independent study sponsored by ACLA demonstrates that such savings could be between $2.4 and $3.2 billion a year. The Center for Health Policy Studies ("CHPS") compared the experience of Medicare and Blue Cross/Blue Shield in direct billing and in non-direct billing states. The CHPS Report, a copy of which is attached as Appendix 3, found that laboratory prices and utilization were dramatically higher in non-direct billing states than in direct billing states. Among the findings of the study were the following:

- Charges for laboratory services were 8.4 to 9.6 percent higher in non-direct billing states than in direct billing states.
- Laboratory utilization per enrollee was higher in non-direct billing states than in direct billing states. For tests reimbursed by Medicare, utilization was 6.5 percent higher and for tests reimbursed by private payors--where incentives for overutilization are greatest--it was 28.3 percent higher.
- Laboratory charges per enrollee under private health insurance programs, a measurement that takes into account both utilization and price differences, were 40.6 percent higher in non-direct billing states.

The report concludes that if a national direct billing law were enacted, savings of between $2.4 and $3.2 billion per year could be achieved in health care expenditures, as a result of reduced utilization and lower prices.

Further, as detailed in the attached health reform proposal, if direct billing were enacted, ACLA would also be willing to accept a cap on non-Medicare reimbursement. Enactment of such a cap would have the effect of substantially lowering laboratory reimbursement in the private sector.

In short, enactment of direct billing would mean that Medicare, private payors and patients would all end up paying fairer prices. Laboratories could also afford to accept lower reimbursement from these payors. Finally, the health care system itself would save at least $12 billion to $16 billion over the next five years because of reduced laboratory utilization and lower prices. This savings figure does not take into account additional reductions in Medicare or the cap on private reimbursement envisioned by our proposals.

3. Response to the Administration's Proposal

With this background in mind, we now turn to a discussion of the Administration's proposal. The Administration has suggested reducing Medicare reimbursement for laboratories from 88 percent to 76 percent of the fee schedule medians, a figure that is derived from an industry report done by the GAO. ACLA believes that there are flaws in that report, and that it is inappropriate to base a major change in policy on its conclusions alone. Based on our review, it appears that the GAO may have substantially overstated the differences between what laboratories earn on Medicare and non-Medicare testing.

Nonetheless, as noted above, if direct billing were enacted, laboratories would be able to accept some additional cuts in reimbursement from Medicare. ACLA wishes to emphasize, however, that it is the efficiencies resulting from the enactment of direct billing that would permit laboratories to absorb such reductions. Without direct billing, these cuts will simply exacerbate the inequities of the current system and many laboratories, especially smaller laboratories and those serving rural and underserved areas, will be unable to survive.

ACLA also could accept a cap on the update in the fee schedules in connection with direct billing, although we believe some adjustment should continue to be made to reflect rising costs faced by the industry. A failure to have some update would actually constitute an additional cut in laboratory reimbursement.

ACLA must object, however, to the Administration's proposed plan that would permit the Secretary to set rates based on changes in technology and market conditions. In the past, HHS and the Administration have submitted proposed changes in reimbursement to Congress, which then has decided whether or not to enact them. The Administration's proposal would not permit the Congress any involvement in the procedure by which payment levels for laboratory services are set, a dangerous precedent in the view of ACLA. If the Department determines that further changes in payment levels are necessary, it should propose such changes to Congress, just as the agency has always done in the past, and then permit Congress to determine whether, and how, to implement those changes.

ACLA has a number of other recommendations for health care reform in the laboratory industry. These include caps on reimbursement from private payors, limitations on the use of profiles, and the enactment of administrative simplification.

These changes are discussed in ACLA's statement on health care reform, which is attached to this testimony.

ACLA appreciates the opportunity to appear before the Committee today and looks forward to working with the Congress and the Administration in creating a fairer market for clinical laboratory services.

Appendix 1

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THE AMERICAN CLINICAL LABORATORY ASSOCIATION SUPPORTS HEALTH CARE REFORM

The American Clinical Laboratory Association ("ACLA") is an organization of federally-regulated, independent clinical laboratories, which represents national, regional and local laboratories located throughout the United States. Over 60 percent of the services furnished by independent clinical laboratories are supplied by ACLA members. These laboratory services play a vital role in the health care delivery system and offer a cost-effective method of diagnosing and monitoring a variety of illnesses and conditions.

ACLA recognizes that fundamental reform of the health care system is urgently needed and, therefore, is proposing a four-part plan to confront the problem of rising costs and increasing utilization of laboratory testing. The centerpiece of this plan is the enactment of a federal law requiring direct billing of laboratory services; i.e., a requirement that the laboratory bill the third-party payor or patient who is responsible for payment, rather than the physician requesting the tests. For the reasons discussed below, ACLA believes enactment of this simple provision would lower utilization, eliminate cost-shifting, and reduce laboratory costs to patients and third-party payors. *If ACLA's plan is enacted, ACLA estimates that it would result in a savings to the health care system of more than 16 billion dollars over the next five years.*

THE CURRENT SYSTEM DISTORTS THE MARKET

Under the present system, physicians can request that laboratories bill them for testing that they order for their non-Medicare patients. Because laboratories cannot order testing themselves, the physician is in the position where he or she can also request — and receive — discounts from the laboratory providing this testing. The physician can then mark-up these tests when third parties and patients are billed. This system gives the doctor a financial interest in the testing that is ordered, and creates incentives that can lead to increased testing. Because of the obvious concerns arising from this arrangement, Medicare requires the laboratory performing the testing to bill the program directly.

The current system also results in cost-shifting because it forces laboratories to increase prices to other payors: to Medicare, to the extent possible, to third-party payors and patients. Medicare has protected itself, to some extent, through the enactment of fee schedules and national limitation amounts. However, patients and third-party payors also end up paying increased prices, either because they bear the mark-up tacked on by the test-orderer, or because laboratories, when they bill patients and third-party payors, must offset physician discounts and reductions in Medicare reimbursement.

PART ONE: ENACT FEDERAL DIRECT BILLING LEGISLATION

Enactment of a federal direct billing law is the single most important part of reforming the present system. It is the one provision that allows achievement of all other goals. It is a simple provision mandating that laboratories performing the testing only bill the person or insurer responsible for payment. Such a provision is already included in S.337, a bill introduced this year by Senators Jeff Bingaman and Howard Metzenbaum. It could also easily be included in a prohibition on self-referral, to which this issue is closely related. Independent studies sponsored by ACLA demonstrate that enactment of a direct billing provision standing alone would reduce health care costs between \$2.4 and \$3.2 billion a year, as a result of lower prices and decreased utilization. This is a savings of at least \$12 billion over the next five years.

PART TWO: ENACT SIGNIFICANT COST-CONTAINMENT MEASURES

If a direct billing law is enacted, laboratories would be able to accept cuts in reimbursement from Medicare and private payors, and all payors will end up paying fairer prices. If direct billing is enacted, laboratories could accept lower reimbursement from Medicare. President Clinton has proposed lowering the national limitation amounts, which act to cap Medicare reimbursement for laboratories, from their current levels of 88 percent to 76 percent of the fee schedule medians. ACLA could accept this cut if it is accompanied by direct billing. This reduction is estimated to save approximately $4.4 billion over five years. When these savings are added to the savings resulting from direct billing, the total package would reduce health care costs by at least $16.4 billion over the next five years, and probably more.

Direct billing would also make it possible for ACLA members to absorb lower prices from private payors, as well. Along with direct billing, ACLA proposes a cap on laboratory payments, set at the actual median of the current Medicare laboratory fee schedules, as defined in Section 1833(h) of the Social Security Act. Enactment of such a provision would have the effect of substantially lowering laboratory reimbursement in the private sector. While it is impossible to calculate precisely how much such a provision would save, as competition could ultimately drive prices below this cap, ACLA believes the savings would be substantial, and would be in addition to the savings already discussed. Further, the combination of direct billing and fee caps will transfer the benefits of price and service competition from the physician to the ultimate payor, either the patient or the third-party payor.

ACLA wishes to emphasize, however, that it is the enactment of direct billing that allows laboratories to propose these cost containment measures. Because of the additional costs that are being imposed on laboratories due to new regulatory and quality control requirements, these additional payment reductions, in the absence of direct billing, will likely be offset by decreases in services and the closing of some facilities, resulting in reduced access to care.

PART THREE: ENCOURAGE MORE APPROPRIATE USE OF PROFILES

One factor that may have led to the increased utilization of testing services is the use of "test profiles." Profiles are a group of related tests that are packaged together. For example, a physician ordering tests for a patient with liver disease may order a "hepatic profile," a group of related tests used for patients known or suspected to have this condition. While profiles are a necessary and valuable tool, it has also been suggested that they may lead to increased testing. For example, in some instances, physicians may order the profile without understanding which tests are included in the package. ACLA believes a process should be established to develop standardized profiles and their components, and to modify them, as necessary, in the future. ACLA would be pleased to work with the Department of Health and Human Services and the various medical societies in developing a limited list of accepted profiles. ACLA also believes that laboratories should disclose to physicians the component tests included in each profile and their prices to third-parties.

PART FOUR: PROMOTE ADMINISTRATIVE EFFICIENCY

First, a system of administrative simplification should be enacted so that it is clear to all health care providers what medical and insurance information must be obtained from a patient. This is especially important for laboratories, which do not usually have direct contact with the patient and must rely on the physician to obtain this information. Second, the number of Medicare carriers processing laboratory claims should be reduced, preferably to a single, centralized carrier. Today, laboratories deal with over 50 different Medicare carriers, all of which have their own procedures and policies. Because laboratories often have testing facilities in many different states, several carriers usually have jurisdiction over each laboratory and sometimes even over a single claim. This system results in unnecessary duplication of effort and a waste of time and money.

Appendix 2

EXPECTED SAVINGS FROM LABORATORY CUTS (in millions)

	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	TOTALS
	(FISCAL YEAR)												
DEFRA '84 1/ (established lab fee schedule)	40	240	300	380									960
COBRA '86 (established fee caps at 115% of the medians) 2/			10	12	22	22	27	37					130
OBRA '87 (3 month freeze on fee schedules; reduction of caps to 100%; reduction in fees for automated tests; limited CPI update) 3/					65	135	225						425
OBRA '89 (reduction in caps to 93%) 4/							85	130	155	185	215		770
OBRA '90 (reduction in caps to 88%; limited CPI update) 5/								90	185	270	325	365	1,235
TOTAL	40	240	310	392	87	157	337	257	340	455	540	365	3,520

1/ Background Material and Data on Programs Within The Jurisdiction Of The Committee on Ways and Means at 161 (1986).

2/ Background Material and Data on Programs Within The Jurisdiction Of The Committee on Ways and Means at 169 (1987).

3/ Background Material and Data on Programs Within The Jurisdiction Of The Committee on Ways and Means at 184 (1989).

4/ 1991 Green Book at 209 (1991).

5/ Id. at 230 (1991).

Appendix 3

IMPACT OF DIRECT BILLING REQUIREMENTS FOR LABORATORY TESTS ON LABORATORY CHARGES, UTILIZATION AND COSTS

INTRODUCTION

The purpose of this study conducted by the Center for Health Policy Studies (CHPS) is to investigate the impact of provider direct billing requirements for laboratory tests on charge levels, utilization and total costs for laboratory tests. If a cost impact is determined to exist, an additional study objective is to estimate potential cost savings if direct billing requirements were to be required for all payers in all states.

Since July, 1984, Medicare has not allowed physicians to bill Medicare for laboratory tests that were performed by other providers, e.g. physician billing for a test when the test was actually performed by an independent laboratory. In most states, there are no direct billing requirements for services paid for directly by the patient or through private health insurance. It is common practice in these states for laboratories to contract with physicians to provide laboratory testing services under monthly billing account arrangements. There is active price competition for physician accounts and prices offered are usually substantially below "retail laboratory prices" -- prices charged by physicians and laboratories to patients and private health insurers. Physicians typically bill and receive fees for laboratory tests which are well in excess of the prices they pay independent laboratories for the tests.[1] This ability to mark up prices for laboratory tests can create strong financial incentives for physicians to order unnecessary tests. Thus, the absence of direct billing requirements can result in an increased number of tests and in higher prices being paid for these tests, by patients and by private health insurers.

In several states, physicians are prohibited from billing for tests that are performed by other providers. In these states, when tests are ordered from independent laboratories, physicians do not have financial incentives to order increased testing. As a result, laboratory service utilization rates can be expected to be lower in states with direct billing requirements than in states without such requirements. Moreover, laboratory test prices may be lower in these states than in states without direct billing requirements because there may be more price competition focused on the patient in direct billing states than in non-direct billing states. In non-direct billing states, much of the competition among laboratories is focused on obtaining physician business.

There is an extensive body of research to support the conclusions that physicians: 1) are aware of financial incentives affecting their practices, and 2) respond to financial incentives in their practice and billing behavior. These studies, which have examined utilization and cost experience for laboratory, radiology and other diagnostic services, have produced findings of additional medical care costs from 40 percent to over 500 percent attributable to financial incentives to perform or order more tests.[2] Within the past year, several studies have been published which focus on the cost impact of physician self-referral practices.[3] While these and earlier studies did not focus explicitly on the cost impact of physician mark-up of laboratory tests, their findings suggest that the strong financial incentives related to the opportunity of physicians to mark-up prices of tests performed by others can be expected to result in increased utilization, higher charge levels and higher claims cost.

Study Research Issues

The following specific research issues are addressed in this study:

1. Are laboratory test prices (charges per test) higher in states with no direct-billing requirements (non-direct billing) than in direct billing requirement (direct billing) states?

2. Do laboratory test prices increase more rapidly in non-direct billing states than in direct billing states?

3. Are laboratory utilization rates higher in non-direct billing states than in direct billing states?

4. Are laboratory claims costs higher in non-direct billing states than in direct billing states?

5. What is the estimated national cost impact and potential cost savings (if any) of a change to direct billing requirements for laboratory tests for private pay patients in all states?

OVERVIEW OF STUDY METHODOLOGY AND DATA SOURCES

The methodological approach used includes a comparison of health insurance claims experience in non-direct billing and direct billing states. Ideally, only private payer experience would be analyzed, as the research issues relate explicitly to laboratory services provided under self pay and private insurance programs. However, only limited private claims experience is available for both non-direct billing and direct billing states which can be used to address the research issues identified above. Two data sets are used in this study.

- Medicare Part B Medicare (BMAD) claims data
- Blue Cross and Blue Shield private program claims data.

The two data sets and methodology used with each are described briefly below.

Medicare Data

The BMAD data used reflect claims experience by Medicare carrier area for a sample of laboratory test procedures for 1988 and 1990. Not included in the data set are hospital inpatient and hospital outpatient claims, which are processed under the Medicare Part A program.

The BMAD data set has the advantages of reflecting national experience for a standard benefit program with demographically similar enrollees in all Medicare carrier localities. Moreover, unlike most other health insurance data sets, reliable data are available on enrollment which allows analysis of utilization and claims cost on a per enrollee basis.

The BMAD data does have one significant disadvantage from the perspective of the research issues being addressed in this study. Because providers are not permitted to bill under Medicare for tests they did not directly perform, regardless of the existence or absence of state direct billing requirements for laboratory tests, one may not observe higher Medicare utilization experience in non-direct billing than in direct billing states, even if utilization rates are higher for the non-Medicare population in non-direct billing states. This deficiency does not affect the analysis of laboratory prices, as submitted charges for specific tests would be expected to be the same for self-pay and privately insured persons as for those covered under Medicare.

Described below are the primary components of the study methodology used in the analysis of Medicare claims experience.

Select sample of laboratory procedures for analysis. A sample of laboratory procedures was selected from a larger list of frequently performed tests under Medicare. The sampled procedures, shown in Exhibit 1, include both those commonly performed in physicians' offices as well as those commonly performed by independent laboratories.

Obtain Medicare claims data. BMAD claims data for 1988 and 1990 were obtained from HCFA for the laboratory procedure codes in the study sample for each of the 56 Medicare carrier areas. The BMAD data includes number of services, submitted charges and allowed charges, by provider type. Medicare Part B enrollment by carrier area was also obtained from HCFA.

Identify states in two direct billing requirement categories: direct billing requirement states, and no direct billing requirement states. There are two states, New York and Rhode Island, which prohibit providers from billing for tests they did not directly perform. New York and Rhode Island are designated as direct billing states. In three other states, Connecticut, Michigan and Pennsylvania, a Blue Shield plan with 50 percent or more of the private health insurance market does not pay for laboratory tests which are billed by a provider that does not directly perform the test. Because of their large market shares, the provider payment practices used by these Blue Shield plans can be expected to exert substantial influence on provider practice and billing behavior. Connecticut, Michigan and Pennsylvania have been designated as direct billing states in the analysis. All other states, in which physicians are not restricted from billing for tests they did not perform directly, are designated as non-direct billing states.

EXHIBIT 1

STUDY SAMPLE OF LABORATORY PROCEDURES*

80012 - Automated multichannel test, 12 chemistry tests
81000 - Urinalysis
82150 - Amylase, serum
82270 - Blood; occult, feces, screening
82550 - Creatine phosphokinase (CPK)
82565 - Creatinine; blood
82643 - Digoxin, RIA
82746 - RIA
82947 - Glucose
84478 - Triglycerides
85031 - Blood count, complete CBC
85650 - Sedimentation rate (ESR)
87205 - Smear, with interpretation
88150 - Cytopathology (PAP Smear)

*80019 - Automated multichannel test, 19 or more chemistry tests, was also included in the procedure sample. However, claims data for this code were inadvertently not included in the HCFA data set provided to CHPS.

Analyze Medicare charge and claims experience. Medicare charge and claims data are combined within each of the two billing restriction categories of states. This is done for each of the 14 laboratory procedure codes in the study sample and for the total of all procedure codes combined. Comparisons are then made between the two categories of states, of charges per test, number of tests per 1,000 enrollees, number of tests per 1,000 office visits and total charges per 1,000 enrollees.

Blue Cross and Blue Shield Data

The second data source used is Blue Cross and Blue Shield claims data which CHPS has access to as a result of an ongoing Multiplan Study of physician costs. Eleven Blue Cross and Blue Shield plans contracted with CHPS in 1991 to conduct a comparative analysis of their charge, claims cost and utilization experience. Claims data were collected and analyzed for a sample of approximately 130 frequently used procedure codes. Among the Blue Cross and Blue Shield (BCBS) plans which participated in the study are Blue Cross and Blue Shield of Rhode Island and Pennsylvania Blue Shield. As noted above, Rhode Island is a direct billing state and Pennsylvania Blue Shield does not pay a physician for a laboratory test unless the physician has actually performed the test. Rhode Island and Pennsylvania are designated as direct billing states in the analysis. The remaining BCBS plans are located in non-direct billing states and allow payment to physicians for laboratory tests if the tests are performed by independent laboratories. The complete list of study plans is provided below:

Direct billing Environments

- **Blue Cross and Blue Shield of Rhode Island**
- **Blue Shield of Pennsylvania**

Non-direct billing Environments

- Blue Shield of California
- Blue Cross and Blue Shield of Indiana
- Blue Cross and Blue Shield of Iowa
- Blue Cross and Blue Shield of Kansas
- Blue Cross and Blue Shield of Kansas City
- Blue Cross and Blue Shield of Massachusetts
- Blue Cross and Blue Shield of New Hampshire
- Blue Cross and Blue Shield of Oklahoma
- Blue Cross and Blue Shield of Texas

Included among the study sample procedures are seven frequently performed laboratory procedures. The seven laboratory procedures are:

- 80019 - Automated chemistry tests, 19 or more tests
- 81000 - Urinalysis
- 82947 - Glucose
- 85031 - Blood count (complete CBC)
- 87060 - throat or nose culture
- 88150 - Cytopathology (PAP smear)
- 88304 - Surgical pathology, level III

The BCBS claims data for the eleven study plans enables us to compare submitted charges per test, number of tests per enrollee (covered person) and submitted charges per enrollee in 1990 between BCBS plans in direct billing environments and BCBS plans in non-direct billing environments.

The Medicare data is used primarily as a source of information on relative charge patterns between non-direct billing and direct billing states. While information is contained in the BMAD data set on utilization and total charges per Medicare enrollee, a direct billing requirement exists under Medicare in all fifty states. Differences which may be found in utilization and total charges between non-direct billing and direct billing states may reflect a spillover effect of financial incentives which exist for private pay patients, i.e., the financial incentive that exists for non-Medicare patients "spills-over" and affects physician behavior for Medicare patients. The Blue Cross and Blue Shield claims experience is used as the primary source of information on relative utilization and total cost experience between non-direct billing and direct billing states.

STUDY FINDINGS

The results of the comparative analysis of Medicare claims experience are summarized in Exhibit 2. Laboratory prices (laboratory charges per test) are 8.9 percent greater in non-direct billing states than in direct billing states. Between 1988 and 1990, charges per test increased more rapidly in non-direct billing than in direct billing states, 11.9 percent compared to 8.4 percent. These total charge per test comparisons include the effects of relatively small differences in distribution of tests between direct billing and non-direct billing states, i.e., there is a slightly more intensive mix of laboratory tests in direct billing than in non-direct billing states. For the same distribution of tests, total charges per test are 8.4 percent greater in non-direct billing states than in direct billing states.

EXHIBIT 2

COMPARISON OF MEDICARE LABORATORY CHARGE, UTILIZATION AND COST EXPERIENCE, DIRECT BILLING (DB) STATES AND NON-DIRECT BILLING (NDB) STATES

	DB States (NY, RI, MI, PA, CT)	NDB States (All Other States)	(NDB-DB)/DB
Lab charges per test*, 1990	$ 11.96	$ 13.03	8.9 %
Percent Change, 1988-90	8.43%	11.92%	
Lab charges per test for same distribution of tests**, 1990	$ 12.02	$ 13.03	8.4
Lab tests per enrollee, 1990	1.23	$ 1.31	6.5
Percent Change, 1988-90	6.28%	5.03%	
Lab tests per 1000 Office visits, 1990	277	322	16.2
Percent Change, 1988-90	-14.42%	-3.97%	
Lab charges per enrollee, 1990	$ 14.72	$ 17.02	15.6
Percent Change, 1988-90	15.24%	17.55%	

*Includes effects of differences in test distributions between NDB and DB states.

**Assumes same distribution of tests in DB as in NDB states.

Also shown in Exhibit 2 are differences between non-direct billing and direct billing states in utilization of laboratory tests per Medicare enrollee and per 1,000 medical office visits. Number of laboratory tests per enrollee and per 1,000 office visits are, respectively, 6.5 percent and 16.2 percent greater in non-direct billing states than in direct billing states. The higher differential between non-direct billing and direct billing states in laboratory tests per 1,000 medical office visits than in tests per enrollee implies a greater number of medical office visits per enrollee in direct billing than in non-direct billing states. The higher rate of visits in direct billing states is likely related to greater relative physician supply in these states. The number of non-Federal physicians per 100,000 civilian population in 1990 is 284.7 in the combined group of direct billing states.[4] This figure is 25.4 percent greater than the number in non-direct billing states (227.1). The finding of 16.2 percent more laboratory tests per 1,000 visits in non-direct billing states than in direct billing states clearly demonstrate that the higher volume of laboratory tests per enrollee in non-direct billing states than in direct billing states is not caused by a possible higher number of patient visits (or proportionately more physicians) in non-direct billing states. Rather, the observed higher laboratory utilization per enrollee in non-direct billing states occurs despite visits per enrollee being lower in non-direct billing than in direct billing states. Given the higher physician population ratio and associated greater number of visits per enrollee in direct billing than in non-direct billing states, we would expect laboratory tests per enrollee to be greater in direct billing states as well. That the reverse is true adds further credence to the view that it is the lack of direct billing requirements that causes higher laboratory utilization rates in non-direct billing than in direct billing states.

As indicated earlier, the higher laboratory test utilization rates in non-direct billing than in direct billing states likely do not fully reflect differences that would be observed for private pay patients, because laboratory tests in all states are subject to direct billing requirements under Medicare. Rather the laboratory utilization rate differential may reflect only the spillover effect from financial incentives that exist for private patients which can affect physician practice behavior for Medicare patients as well.

The last row in Exhibit 2 provides data on total laboratory charges per enrollee for the 14 laboratory procedures in the Medicare study sample. These figures combine the effects of submitted charges per test and number of tests per Medicare enrollee. Total charges per enrollee are generally in excess of amounts actually paid on average for laboratory tests, because maximum fee levels are often less than amounts charged by providers. However, previous research indicates that differences in total charges for laboratory tests between localities are good proxies for differences in amounts actually paid by private payers for laboratory tests between those localities.[5] Thus, the existence of high or low laboratory charge levels in a specific locality is generally a good indicator of whether actual fees received by laboratories from private payers are, respectively, relatively high or low in that locality.

Total laboratory test charges per enrollee is $17.02 in non-direct billing states, or 15.6 percent higher than in direct billing states. It is important to also note from the figures shown in Exhibit 2 that over the 1988-1990 period, percentage changes in laboratory charges per test, laboratory tests per 1,000 medical office visits and laboratory charges per enrollee are each higher in non-direct billing states than in direct billing states. Thus, there is evidence that cost differences between non-direct billing and direct billing states are increasing over time.

As discussed above, the Blue Cross & Blue Shield data are better suited to developing estimates of the impact of direct billing requirements on utilization of laboratory tests than the Medicare data, because the financial incentives affecting physician laboratory test ordering patterns apply to private insurance covered services and not to Medicare covered services. Findings from the Blue Cross & Blue Shield laboratory claims analysis are summarized in Exhibit 3. Laboratory charges per test are 9.6 percent higher in non-direct billing states than in direct billing states. This figure is approximately one percent higher than the 8.4 percent charge per test differential computed based on the Medicare data. Laboratory charges are higher in non-direct billing states than in direct billing states, even though the cost of living is lower on average in the non-direct billing states than in the direct billing states.

Total tests per enrollee are 36.9 percent greater in non-direct billing states than in direct billing states. However, after adjusting for differences in distributions of tests between direct billing states and non-direct billing states, the difference in number of tests per enrollee between non-direct billing and direct billing states is reduced to 28.3 percent. This figure compares to an estimate of 6.5 percent differential under Medicare, which is interpreted as a spillover effect from financial incentives affecting physician laboratory test ordering patterns for private pay patients. The last row in Exhibit 3 shows the differential between laboratory charges per enrollee in non-direct billing and direct billing states.

EXHIBIT 3

COMPARISON OF BLUE CROSS AND BLUE SHIELD CHARGE, UTILIZATION AND COST EXPERIENCE, IN DIRECT BILLING (DB) AND NON-DIRECT BILLING (NDB) STATES

	DB States	NDB States	(NDB-DB)/DB
Lab charges per test, 1990*	$ 19.05	$ 20.88	9.6 %
Lab tests per enrollee, 1990	.300	.411	36.9
Lab tests per enrollee adjusted for intensity, 1990**	.320	.411	28.3
Lab charges per enrollee, 1990	6.33	8.90	40.6

*Computed using same distribution of tests in DB as in NDB states.

**Differences between NDB and DB states in adjusted lab tests per enrollee (28.3%) are computed by netting out effect of difference in average charges per test between NDBR and DBR states (9.6%) from difference in lab charges per enrollee (40.6%).

Laboratory charges per enrollee are 41 percent greater in non-direct billing than in direct billing states.

NATIONAL COST IMPACT OF DIRECT BILLING REQUIREMENTS

The final research objective of this study is to estimate the National cost impact in 1992 dollars of a change to direct billing requirement in all states. The underlying assumption of the estimation approach used is that cost and utilization experience in non-direct billing states would be the same as in direct billing states if direct billing requirements were to be imposed at the national level. The estimation methodology used is outlined below:

Step 1. Estimate existing laboratory expenditures. An estimate is developed of private payor (health insurer and consumer pay) laboratory expenditures for laboratory tests performed outside of the hospital setting. It is assumed that government laboratory costs and costs of tests performed for hospital patients would not be affected by change from non-direct billing to direct billing status for tests performed for private pay patients outside of the hospital setting. The estimation methodology requires the following steps:

- Obtain HCFA estimate of private insurance and direct consumer expenditures for physician and other professional services for 1992: $135.2 billion[6].

- Estimate laboratory expenditures as a proportion of total Blue Cross and Blue Shield expenditures for physician and other professional services. The ratio of Blue Cross and Blue Shield plan laboratory charges to total physician charges is 9.3 percent.

- Multiply $135.2 billion by 9.3 percent -- $12.57 billion. This figure is towards the low end of the range of estimates of expenditures for laboratory services outside of the hospital setting[7].

Step 2. Determine the resident populations in direct billing and non-direct billing states. The 1991 resident population of direct billing and non-direct billing states is computed from data contained in the 1991 Statistical Abstract[8].

- direct billing states (NY, RI, MI, PA, CT) -- 43,457,000
- non-direct billing states (all other states) -- 205,253 million

Step 3. Compute per capita laboratory costs in direct billing and non-direct billing states. Using basic algebra, we compute the average cost per capita in direct billing and non-direct billing states based on the following findings from the analysis of Blue Cross and Blue Shield claims experience: total laboratory charges per covered person are 40.6 percent greater in non-direct billing states than in direct billing states[9].

Average per capita private pay laboratory costs for tests performed outside of the hospital setting are estimated to be:

non-direct billing states -- $53.22
direct billing states -- $37.86

Difference -- $15.36 (41 percent).

Step 4. Compute estimates of national cost impact of adopting national direct billing requirements. The final step in the estimation process is to multiply the non-direct billing-direct billing per capita cost differential by the population in non-direct billing states. The resultant estimates of cost savings which could result from a national change to direct billing is: 205,253,000 x $15.36 = $3.15 billion.

This estimate is appropriate if there are no price controls or national fee schedule for laboratory tests, which could substantially reduce or possibly eliminate price differences among laboratories. However, if some form of price controls or a national fee schedule is adopted, the estimate of potential cost savings resulting from imposition of direct billing requirements may be too high, because it incorporates the effects of both laboratory test utilization and price differences between non-direct billing and direct billing states. A more conservative estimation approach, which is based only on estimated differences in utilization between non-direct billing and direct billing states (28.26 percent), results in a projected savings from adoption of direct billing requirements at the national level of $2.377 billion[10].

CONCLUSION

The analysis of Medicare and private insurance claims experience yield similar findings regarding the impact of direct billing requirements for laboratory tests on charge and utilization patterns:

- Laboratory charges per test are higher in non-direct billing states than in direct billing states: 8.4 – 9.6 percent higher.

- Laboratory utilization rates are higher in non-direct billing states than in direct billing states: 6.5 percent higher under Medicare and 28.3 percent higher under private insurance.
- Laboratory charges per enrollee are substantially higher in non-direct billing than in direct billing states: 15.6 percent higher under Medicare and 40.6 percent higher under private insurance.

In addition, analysis of Medicare trend data indicate more rapid growth between 1988 and 1990 in non-direct billing than in direct billing states for all of these variables. It is also of interest in interpreting the study findings that the direct billing states, New York, Rhode Island, Michigan, Pennsylvania and Connecticut, are characterized by, on average, higher costs of living and higher physician-population ratios than the non-direct billing states. Because of these factors, we would expect, in the absence of any effects of direct billing requirements, laboratory charge levels and utilization rates to be higher in direct billing states than in non-direct billing states. Study findings which indicate the reverse to be true provide substantial support for the view that it is the direct billing requirement that is the cause of higher charge and utilization experience in non-direct billing states, rather than other factors.

The national cost impact of lack of direct billing requirements for laboratory tests and potential savings which could result from adoption of direct billing requirements in all states is estimated to be in the range of $2.4 - $3.2 billion. We believe that these estimates are reasonable, but rough approximations of expected cost savings. Under direct billing requirements, we can reasonably expect reduced incentives to perform unnecessary tests. This should result in a reduced volume of tests. We can also expect more competitive pricing for tests as the locus of price competition among independent laboratories changes from that of the wholesale market -- physicians' monthly billing account business, to that of the final product market -- consumers and health insurers,
who pay for medical care services on their behalf.

FOOTNOTES

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5. Dyckman, Z. Multiplan Study of Physician Claims Experience, Center for Health Policy Studies, January, 1993, Chapter 3.

6. Sonnenfeld, S.T., Waldo, D.R., Lemieux, J.A. and McKusick, D.R. "Projections of National Health Expenditures through the Year 2000," Health Care Financing Review, Volume 13, No. 1 (1991), 1-29.

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8. U.S. Bureau of the Census. Statistical Abstract of the United States - 1991, (111th Edition), 1991. Ideally, the population figures that should be used are total population, less those covered under Medicare, Medicaid, CHAMPUS and other government health benefit programs. However, the ratio of population in non-direct billing to direct billing states does not differ markedly if total population is used instead.

9. Solve for X = Per capita laboratory expenditures in direct billing states.

205,253,000 x 1.4057X + 43,457,000X = $12.57 billion
331,981,000X = $12.57 billion
X = $37.86
1.4057X = $53.22
Per capita difference between
non-direct billing and direct billing states = $15.36

10. Solve for X = Per capita laboratory expenditures in direct billing states.

205,253,000 x 1.2826X + 43,457,000X = $12.57 billion
306,715,000X = $12.57 billion
X = $40.98
1.2826X = $52.56
Per capita difference between
non-direct billing and
direct billing states = $11.58

AMERICAN COLLEGE OF PHYSICIANS

MEDICARE REIMBURSEMENT SURVEY

Physicians in Georgia

Introduction

In order to determine how recent changes in Medicare reimbursement policies have affected its members, The American College of Physicians (ACP) has surveyed members in selected areas--including the state of Georgia.

A four-page Medicare Reimbursement Survey was mailed to 1,145 ACP members in Georgia. Just over half of them returned completed surveys to the ACP (52%).

The ACP contracted with Mathew Greenwald & Associates, Inc. to code and keypunch the surveys, produce a data tabulation book, and prepare this written report.

Profile of the Survey Respondents

Large majorities of the Georgia physicians who completed surveys are male (88%) and Caucasian (86%). Their average age is 46 years old; with one in three less than 40 years old (35%) or age 50 or older (33%).

On average, physicians in Georgia report they have been in practice for almost fifteen years. About half report practicing for ten years or less (44%), while one-fourth have been practicing for more than 20 years (23%).

Certifications

Almost all of the doctors indicate they are certified with the American Board of Internal Medicine (94%), and about four in ten also report they are certified in a subspecialty (38%).

Among those with subspecialty certifications, Cardiovascular Disease/Cardiology is named most often (20%), followed by Gastroenterology (13%), Pulmonary Diseases (10%), Nephrology (9%), and Endocrinology (9%).

Practice Information

Six in ten Georgia physicians report that, on average, they devote between 41 to 80 hours per week to patient care (59%); another 12% say they care for patients more than 80 hours a week. Eleven percent say they devote between 20 to 40 hours per week to patient care, while 7% spend less than 20 hours per week. Nine percent report that they do not devote any time to patient care.

After providing the statistical information reported above, the doctors who indicated they do not spend any time on patient care were instructed to stop answering the questionnaire and to return their survey to the ACP.

The remainder of this report is based on the 533 respondents who reported they devote at least some time each week to patient care.

On average, these doctors indicate that they spend about half of their practice time as a general internist (51%), and about half in subspecialty(ies) (48%). Interestingly, though, while about one doctor in three reports spending all his/her practice time as a general internist (34%), less than half that many spend all their time in a sub-specialty (14%).

Three-quarters of the Georgia doctors state they perform most of their clinical activity in private practice (75%). Among the rest, 12% say they perform this work primarily in an academic institutional practice, 7% in a government, military, or publicly funded facility, and 2% in a Health Maintenance Organization.

Practice arrangements among Georgia physicians are varied. Almost four in ten report they practice in a single specialty group (39%), while smaller proportions are in: a solo practice (27%), a multi-specialty group practice (18%), or some "other" situation (12%).

Among those respondents in a single specialty group practice, the average group size is four physicians. Among those in a multi-specialty group practice, the average practice size is 96 physicians.

Fee-for-service is the main method by which most of the physicians are paid for their clinical work (70%). Almost all the others are on a fixed salary (25%).

Medicare

Among those providing answers to these questions, physicians report that, on average:

- 45% of their patient population is covered by Medicare,
- 52% of their practice time is spent with Medicare patients, and
- 39% of their net income comes from Medicare.

(However, about 10% did not answer the population and practice time questions, and 17% did not answer the income question.)

More than four in ten Georgia physicians report that half or more of their patients are covered by Medicare (44%), 58% say at least half of their practice time is spent with Medicare patients, but only 29% claim at least half of their income comes from Medicare.

On the other hand, 12% report that less than one-quarter of their patients are covered by Medicare, 10% say less than a quarter of their practice time is spent with these patients, and 17% claim less than one-quarter of their income comes from this source.

As the chart below indicates, there has been a slight decrease in the acceptance of new Medicare patients since January, 1992--the date the new Medicare fee schedule was implemented.

	Before 1/ 1/92	After 1/ 1/92
- Accept(ed) new patients into practice	88%	87%
- Accept(ed) new Medicare patients	83%	74%
- Accept(ed) new Medicaid patients	55%	53%
- Accept(ed) new patients only under a certain age	7%	10%

Similarly, just a few physicians--only 8%--say they have transferred care of their Medicare patients to other physicians because of the new Medicare fee schedule; almost nine in ten say they have not (86%).

Evaluation and Management (EM) Codes, Current Procedural Terminology (CPT) Codes, and Resource-Based Relative Value Scale (RBRVS)

Most physicians in Georgia do not believe that, in general, the new EM CPT codes accurately reflect either what they do (71%) or the time involved in each visit (78%). Far fewer think the codes reflect what they do (19%) or the time involved (11%). (In each case, however, about 10% of the physicians did not answer these questions.)

Seven in ten Georgia physicians indicate that their use of the new EM CPT codes has not been reviewed by a Peer Review Organization (PRO) or other Medicare carrier (70%). Only 18% say it has, while the remainder did not answer this question (12%).

Among those relatively few physicians whose use of the new codes has been reviewed, 39% indicate they have undergone just one review, 11% two reviews, 12% three to ten reviews, and 9% more than ten reviews. Overall, the average number of reported reviews is eight and one-half.

Most doctors say that their code review(s) resulted in no change, although about a quarter report at least one review resulted in a downgrading.

About one-third of the Georgia physicians indicate that they have appealed at least one code review (31%), with four in ten of them reporting at least one favorable ruling (41%).

About two-thirds of the Georgia doctors believe that the impact of the Medicare fee schedule/RBRVS on their practice has been either negative (46%) or very negative (18%). Few physicians feel it has had a positive impact (5%), while 21% think it has had little or no impact.

Effect of Code Changes On Income

Many of the physicians indicate they are "unable to say" how much either their net income (30%) or their income per Medicare patient (39%) has changed since January 1, 1992, while some just do not answer either question (about 13%).

Among those who answer the questions, doctors report their net income has declined an average of eight percent, while their income per Medicare patient has declined an average of fourteen percent. Specifically, about one doctor in three claims that their net income (30%) or their income per Medicare patient (37%) has declined. Some say there has been no change in their personal income (22%) or their income per Medicare patient (7%); while very few say either figure has increased (5%, 4%).

Among those who report a change, doctors report that their personal income has declined (since January, 1992) an average of seven percent because of RBRVS/CPT code changes, and an average of five percent because of loss of payment for EKG interpretations.

Similarly, doctors who say their income per Medicare patient has changed indicate it has declined (since January, 1992) an average of twelve percent because of RBRVS/CPT code changes, and an average of eight percent because of loss of payment for EKG interpretations. (Although, again, significant proportions do not give answers for either question--particularly the one about EKGs.)

Other Beliefs

In response to a series of three questions, the Georgia doctors say that, if they were choosing today whether to become a physician:

* 42% would make the same choice,
* 28% would become a physician, but choose a different specialty,
* 19% would choose a different profession altogether.

However, for each question, between one-third to one-half indicate that they are not sure what they would do or do not check any answer.

More than half of the doctors say that changes in Medicare reimbursement influenced their answers to the three questions reported above (58%); 30% say they did not.

Similarly, about one doctor in three contends that problems associated with Medicare (the "hassle factor") have caused them to change their time of retirement (33%). However, very few--only 8%--say these changes have actually caused them to change their specialty or subspecialty.

Physicians suggest that they are significantly less satisfied with the practice of internal medicine now compared to when they first started practicing. As the chart below depicts, almost nine in ten physicians assert they were satisfied with internal medicine when they started practicing (88%). However, fewer than half that many are currently satisfied practicing internal medicine (37%). Moreover, the share of doctors who declare they are currently very satisfied is significantly lower, from 50% to only 7%.

Satisfaction with the Practice of Internal Medicine	When They Started Practice	In Their Present Practice
Very Satisfied	50%	7%
Satisfied	38%	30%
Neither Satisfied Nor Dissatisfied	4%	20%
Dissatisfied	2%	27%
Very Dissatisfied	1%	10%
NO RESPONSE	7%	7%

Follow-up

Finally, about half of the Georgia survey respondents provided their name (52%) and phone number (51%), and indicated that they could be called to discuss these issues further (49%).

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STATEMENT OF THE
AMERICAN COLLEGE OF RHEUMATOLOGY
TO THE HOUSE ENERGY AND COMMERCE COMMITTEE
FOR THE RECORD OF THE HEARING
MARCH 31, 1993

RE: MEDICARE PART B BUDGET ISSUES

The American College of Rheumatology (ACR/the College) is pleased to submit a statement to the House Energy and Commerce Committee for the record of the March 31, 1993 hearing on the Administration's 1994 health budget. The College is committed to efforts to stimulate the economy and reduce the federal budget deficit.

The ACR is the professional organization of rheumatologists. It includes practicing physicians and research scientists who are dedicated to preventing disability, healing and eventually curing more than 100 types of arthritis and related disabling and sometimes fatal disorders of the joints, muscles, and bones.

Our comments will focus on three of the President's budget proposals which affect the Medicare Part B program. Specifically, the plans to (1) phase in a resource-based practice expense index for the Medicare Physician Fee Schedule (MFS); (2) reduce the Medicare conversion factor by 2 percentage points for all services except primary care; and (3) reduce the default formula for the Medicare Volume Performance Standards (MVPSs) and the conversion factor updates.

Resource-Based Practice Expenses (RBPEs)

The ACR has been a strong supporter of basing the practice expense component of the MFS on resources. We have always supported this in concept because we believe that basing payments on resources is the most equitable way to reimburse physicians.

The current historical charged based methodology for assigning practice expense relative value units to physician services continues to create inequities for primary care and other evaluation and management oriented physicians. Only 54 percent of the Medicare Physician Fee Schedule (the work component) is resource based. Practice expense (41 percent) and malpractice expense (5 percent) continue to be based on distorted historical charges. The effort to reform Medicare physician payment is only half finished.

While we therefore support efforts to move to a resource based practice expense index as quickly as possible, we are very concerned about the President's proposal in this area.

The President's Proposal on RBPE: Phase In and Reductions -- The President's plan starts off with a good idea. It would phase in resource-based practice expenses beginning in 1997; although the actual method would need to be developed and more data collected before that time. This element of the President's proposal has been recommended to Congress by the Physician Payment Review Commission (PPRC) and we believe it is a step in the right direction. The President's plan, also however, calls for reductions in the current practice expense relative value units (RVUs) for certain services in 1994, 1995, and 1996, prior to the phase in of resource-based practice expenses.

Specifically, the President's proposal would "reduce the practice component...when it exceeds the value of the work component[1]." The proposal "would reduce practice expenses in relation to the relative value work units by one-half of the difference between practice expense and physician work relative value units[2]."

When the practice expense value exceeds the work value for a particular service, we understand that the Administration is planning to reduce the practice expense RVU by 25 percent of the difference between the PE and work values in 1994; 50 percent of the original difference in 1995, and 75 percent of the original difference in 1996. This is the same as reducing the PE values by 25 percent of the original difference between work and PE each year for 1994, 1995, and 1996. The President's plan also sets a floor of 110 percent of the work amount. That is, the practice expense value cannot be reduced below 110 percent of the work RVU under the President's proposal. The savings from this plan is estimated at a little over $2 billion over a four year period.

ACR's Concerns -- If the President's plan on resource based practice expenses is implemented as written, the College is very concerned that there won't be enough monies left in 1997 and beyond for sufficient redistribution to services with undervalued practice expenses including primary care, or that redistribution will never take place if future further cuts are sought at that time.

The College and many others have always supported the Resource-Based Relative Value Scale (RBRVS) which was used for the MFS because philosophically we thought it was a much more equitable way to pay physicians than via historical charges. Physicians supported this change because they understood that funds would be redistributed from overvalued surgical procedures to undervalued evaluation and management (EM) services. While this redistribution has occurred through the work component of the fee schedule, EM services and particularly primary care remain undervalued because of the historical charge based system for practice expenses.

Rheumatologists experience significantly higher practice costs as a percentage of income than most physicians because they are primarily office based, see fewer patients in day while providing lengthier visits, and for the most part cannot rely on better paid invasive surgical procedures or diagnostic testing to generate additional income to cover their overhead costs. According to Dr.

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[1] A Vision of Change for America, Executive Office of the President, Office of Management and Budget (February 17, 1993), pages 97-98.

[2] ibid.

Hsiao, the author of the RBRVS, it was reported that practice expenses for rheumatologists were 54 percent of their income -- the highest percentage of any other medical specialty studied.[3]

While we would like to see resource based practice expenses implemented in a budget neutral manner, we understand that medicine must do its part to contribute to reducing the federal budget deficit.

ACR's Suggested Alternative for Deficit Reduction --

Instead of only reducing the practice expense (PE) relative value units (RVUs) for services with higher PEs than physician work values (with a floor of 110 percent of the work amount) -- reduce PE values faster and deeper for overvalued services using the same or a similar method and at the same time increase PE values for undervalued evaluation and management services, particularly office visits; allowing the same level of savings as the President's current plan. This would clearly show Congress' commitment to encouraging primary care and would have the support of the primary care community.

Specifically, it could be done by:

1. **accelerating the transition.** For example, instead of reducing the practice expense RVUs for overvalued procedures by 25 percent each year, the RVUs could be reduced by 33 percent each year. Or, one could front load the reductions by taking 50 percent the first year and a little less each additional year (front loading would also probably save more money in the long-run, due to compounding).

2. **lowering the floor.** The current floor of 110 percent of the work RVU -- the maximum amount that the practice expense RVU could be reduced under the President's plan -- could be lowered further to 100 percent or 95 percent of the work value, for example.

3. **applying all the additional saving that would result from accelerating the transition and lowering the floor to increasing practice expense RVUs for office visits and other evaluation and management services.**

4. To make this a more acceptable proposal to the medical profession, Congress may want to consider asking the Physician Payment Review Commission to identify and publish a list of services that current available evidence suggests are overvalued and undervalued as an alternative to arbitrarily applying reductions to any service when the practice expense RVU exceeds the work RVU.

5. Also, if the President's proposed method is pursued, Congress may also want to consider asking HCFA to publish the list of services that would be affected and what the reductions (for overvalued services) and increases (for EM services, especially office visits) would look like when you set the floor or accelerate the transition differently each year from the proposed method. We have not been able to run these numbers ourselves.

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[3] "Relative Cost Differences Among Physicians' Specialty Practices," by Becker, Dunn, and Hsiao, JAMA, October 28, 1988, page 2400.

We believe our suggested alternative proposal is a fair way to achieve the same amount of savings as the President's plan and at the same time show Congress' commitment to improving payments for primary care services, thus encouraging medical students and residents to enter into primary care.

Full Medicare Fee Schedule Increase for Primary Care Services

The College fully supports the Administration's plan to exempt primary care from the reductions proposed for all other physician services. The President's proposal would reduce the Medicare conversion factor by two percent for all services except primary care (which in the past has been defined in the Medicare statute as office, nursing home, and home visits). If these reductions are taken at the same time the Medicare update is provided based on the current MVPSs (which we understand is the Administration's intent), this proposal would in effect provide primary care with a full conversion factor update while reducing the amount of the update for all other services.

This would represent the first time in three years that primary care has received an update equal to inflation. By contrast, the 1993 update for primary care services was only 0.8 percent, compared to 3.1 percent for surgery -- the exact opposite of what should have been done to avert a crisis in primary care.

The President's plan appears to recognize that if cuts in Medicare are required, they should be targeted toward higher-paid services and the specialties that provide them rather than toward primary care. As objections are raised by some to other Medicare cuts, the primary care update could be at risk of being reduced. We ask you to oppose such measures to safeguard primary care.

Reduction in the Defaults for the Medicare Volume Performance Standards and Updates

The purpose of the President's proposal in this area is to reduce the amount of increases in physician fees in future years. The plan would reduce the Medicare Volume Performance Standard (MVPS) default formula and the default update for Medicare payments to physicians. **Unless a special provision is provided for primary care, this proposal would inadvertently negatively impact on primary care services.**

Rather than lowering the default MVPSs for both surgery and nonsurgery, the College recommends that a separate and higher MVPS be provided for primary care and other evaluation and management services, even if that requires a greater reduction in the MVPS for all other services to maintain the intended savings. This recommendation is for the default alone, as the College would prefer the Congress to act each year with respect to a primary care update; and that the conversion factor update for all evaluation and management services be determined outside the MVPS framework. This preferred approach has the support of the Physician Payment Review Commission.

Summary

The American College of Rheumatology:

1. supports the concept of phasing in a resource-based practice cost methodology for the Medicare Fee Schedule, but believes that the practice expense relative value units (RVUs) for visit services that are now too low should be increased, rather than just lowering the overpriced practice expense RVUs for procedures. The College has offered an alternative proposal (detailed above) which could achieve the same level of savings as the President's plan, while at the same providing an incentive to primary care.

2. supports the Administration's proposal to provide the full Medicare Fee Schedule increase (equal to inflation) to primary care services. This primary care update should not be reduced to achieve budget savings elsewhere. Efforts to reduce the deficit should be directed at higher-paid services and the specialties that provide them.

3. recommends that a separate and higher Medicare Volume Performance Standard (MVPS) be given to all evaluation and management services including primary care under the default formula even if that requires a greater reduction in the MVPS for all other services to maintain the intended savings. Instead of allowing the default to kick-in, the College would prefer that Congress act each year to set the primary care update and that the amount be determined outside the MVPS framework consistent with health policy goals of providing incentives to primary care.

The American College of Rheumatology is pleased to share our views with this committee on the President's Medicare budget proposals. We believe that the Congress and the Administration want to support and encourage primary care even in this age of budget deficit reduction. Our recommendations would do just that.

acrec/bjn

TESTIMONY
OF THE
AMERICAN NEPHROLOGY NURSES' ASSOCIATION

The American Nephrology Nurses' Association (ANNA) is the professional organization representing registered nurses specializing in the care of patients with end-stage renal disease. Nearing our 25th year as a professional society and representing over 8000 members, ANNA has consistently provided relevant information on the ESRD program since the inception of the program in 1972.

The ESRD program now provides treatment coverage for more than 150,000 dialysis and transplant patients. Total program costs exceed $5 billion annually, but these costs are directly related to the increasing number of patients initiating treatment each year. (1991 estimated data indicates more than 45,000 new patients started therapy that year.)

Unlike other Medicare funding where reimbursement has been adjusted to reflect inflationary costs, funds for the ESRD program have been reduced 3 times over the past decade (1983, 1986 & 1987, via Graham-Rudman). Only after years of successful lobbying efforts by all members of the renal community did the program receive a dismal increase of 1^{\underline{00}}$ per treatment in 1991.

- **ESRD Annual Update**

As the professional association representing nephrology nurses who provide direct care for this patient population, it is our responsibility to assess the changing needs of the patients within our care. Our members have stressed the critical situation that now exists in most outpatient dialysis settings. The current reimbursement rates and inflation have made it difficult to continue providing quality care to an aged more complicated patient population. As recommended in the NAS/IOM study, "Kidney Failure and The Federal

Government," the composite rate for dialytic treatment should be "updated yearly, as in the practice for the rest of Medicare."

In The Omnibus Budget Reconciliation Act of 1990, Congress asked the Prospective Payment Assessment Commission (ProPAC) to conduct a study to determine the costs, services and profits associated with dialysis treatment facilities.

In its March 1, 1993 annual report to Congress, ProPAC recommended the composite rate payment for dialysis services should be updated by 2.5% for FY '94. This recommendation is based on:

- a projected increase in the market basket for dialysis services at 4.5%;
- a +1% to reflect costs associated with scientific and technological advances;
- a -1% to encourage productivity; and,
- a discretionary 2% adjustment to "reflect the relationship between payments and estimated FY '93 costs."

ANNA supports the factors defined above upon which the update is based except for the discretionary adjustment. Audited cost reports do not reflect costs now incurred by dialysis facilities to comply with OSHA bloodborne standards and the newly implemented CLIA regulations. CLIA regulations now require increased monitoring and testing costs to meet quality assurance requirements. As dialysis clinics are considered a setting where bloodborne diseases can be prevalent, adherence to OSHA guidelines, in particular waste removal, has increased operating costs.

Dialysis facilities have been forced to implement cost-saving measures due to restricted reimbursement and inflation. The labor component of the dialysis service was often targeted. Facilities continue to substitute unlicensed personnel for registered nurses.

The patient population now presenting for dialytic treatment is more aged and medically unstable than in prior years. Any additional changes of this type in the labor force will place the patient at risk for numerous complications, both technical and medical, as well as hospitalization.

The perception that chronic renal failure patients who receive outpatient dialysis therapy are stable and treatments uncomplicated is both dangerous and unsubstantiated. Patients require at least direct supervision of unlicensed personnel by registered professional nurses.

ANNA is sensitive to the need to decrease the federal deficit and reduce excessive health care spending. However, we strongly believe that a rate increase, as recommended by ProPAC and NAS/IOM is needed to insure quality health care for these beneficiaries and reduce the potential risk of increased morbidity and mortality.

- **Setting EPO payment at $10.⁰⁰ per 1000 units of EPO.**

This proposal had been put forth last year with the anticipated savings to be used to extend coverage for immunosuppressive therapy post transplantation. ANNA encouraged the extension of immunosuppressive coverage and still believes that this extension is needed if graft failure due to non-compliance is to be resolved. Too often, patient non-compliance is due to inability to afford prescribed medications. In too many incidents, patients must decide on buying medications or paying for basic needs such as food, clothing or housing for their families.

The proposed reduction in EPO payments in the President's budget is based on a perception that costs are well below the Medicare payment rate. However, this perception is invalid because most facilities can not negotiate the required volume discounts given the reality of a single manufacturer and the classification of EPO as an orphan drug.

Therefore, ANNA recommends that no further cuts be made to the end stage renal disease program, such as the proposed reduction in EPO payment, without a comprehensive evaluation of the potential effects of any such changes in reimbursement on patient outcomes.

- **Extending provision requiring secondary payment for certain Medicare beneficiaries with End Stage Renal Disease (ESRD).**

Under current law, Medicare is the secondary payor for ESRD beneficiaries with coverage through group health plans. Medicare makes secondary payments for the first 18 months of entitlement, after which Medicare becomes the primary payor.

ANNA supports that this provision be made permanent and that consideration be given to extending the secondary payor provision to 24 months. This extension would provide additional savings to Medicare that could then be used to offset the costs of the composite rate update.

The GAO study, Medicare ESRD Expenditures, Extending Medicare Secondary Payor Provision, states that this provision has shifted "slightly more than 1%" of the total Medicare expenditures spent in 1989 for beneficiaries with ESRD. The report finds the amount of this cost shifting to be relatively small. Given the data analyzed by ProPAC on cost shifting under PPS, this amount in not near the magnitude of cost shifting seen elsewhere within the PPS.

The report further states that the number of beneficiaries affected was small because of the relatively small numbers of patients who seek employment or are employed. Data from the HCFA shows that the mean age of the patient now initiating dialysis is 62 and that the greatest increase in new cases is for patients 65 years or older (P. Eggers, 1991). Therefore, most patients now initiating therapy are either retired or approaching retirement and not seeking employment.

The end stage renal disease program has remained a success, in part, due to the commitment by Congress to assure quality patient care. As Congress debates a new health care reform proposal, we believe there is much to be learned from the success and limitations of the ESRD program. Medicare entitlement has provided access to care for many patients previously denied treatment. Yet, a small percentage of patients are not entitled to Medicare and must be considered in any health care package that provides universal access.

More importantly, as a program largely dependent on government reimbursement, the effects of price controls on quality of care and patient mortality must be evaluated.

ANNA appreciates the opportunity to provide this written testimony to the committee and is available if further information is needed.

Thank you.

STATEMENT OF THE AMERICAN ORTHOTIC AND PROSTHETIC ASSOCIATION

Introduction

The American Orthotic and Prosthetic Association (AOPA) is the national membership organization which represents more than 800 allied health care provider firms who serve the needs of the physically challenged throughout the United States. Orthotic and prosthetic practitioners employed by AOPA member firms design and fit orthoses (braces) and prostheses (artificial limbs) which enable these physically challenged individuals to overcome often serious and crippling injuries and return to productive lives.

These are AOPA's views on the President's budget proposal and proposals to modify Part B of the Medicare program relating to orthotics and prosthetics (O&P). While we discuss the President's budget, we recognize that this budget is also a vehicle used develop and implement public policy.

The Administration's Proposals for Fiscal Year 1994

In introducing his budget this year, President Clinton stressed the need to invest today to build a stronger tomorrow, a tomorrow that does not demand enormous amounts of money and sacrifice to right pervasive problems. Instead, investment made today for prevention and preservation will build a strong future, one not built upon a devastatingly weak foundation. We believe these principles hold true for the successful rehabilitation of patients who suffer muscular, skeletal and limb-loss disability. Specifically, early investment in rehabilitation that provides braces and artificial limbs mainstreams people. Mainstreaming entails restoring people to their optimum level of function, allowing them to pursue employment and other activities, and thus lead productive, independent lives. These independent Americans contribute to society.

Failing to restore individuals to their optimum level of function increases dependency, thus limiting their ability to remain productive, economically independent members of society and increasing their need for added medical, social service and state care, which impose great expenses upon society.

To accomplish the goals of reducing health care expenditures tomorrow by providing assistive technology today, such as quality orthotics and prosthetics, it is crucial that O&P care is:

1. recognized by Medicare as **distinct** and **separate** from the vending and renting of durable medical equipment; and,
2. provided by qualified board certified practitioners.

Separation of O&P from DME and Qualifications of Providers

In the past, confusion has arisen over the definition of orthotics and prosthetics. While in a limited sense the definition of orthotics and prosthetics has been addressed by Congress, the results have been very broad and have included a number of items not characteristic of O&P care. To clarify this confusion, the organized field of O&P is strictly defining orthotics as "braces" and prosthetics as "artificial limbs", and proposes that Congress do the same.

Orthotics and prosthetics are radically different from durable medical equipment in that O&P health care "services" are highly individualized to specific patient needs, and are as much a professional "service" as a "product". The "product" element of the O&P practice is only part of the total package of treatment provided by an O&P practitioner, and reimbursement for the service element is specifically included in O&P's Medicare reimbursement codes. O&P devices are generally custom-fabricated and custom-fit for each individual patient, unlike DME products, which are reusable and rentable by other individuals.

The approximately 2,700 certified practitioners provide artificial limbs and braces that are designed in response to a physician's perscription and meet the unique needs of individual patients. O&P patient care services include evaluation, consultation, design, individual fabrication, fitting and patient orientation training.

Further, the O&P medical field is completely different from DME in that O&P has a defined body of technical knowledge, a core of certified practitioners, and a well-established post-baccalaureate education program offered at eight major American universities.

It is important to note that these wide differences in O&P and DME were addressed by Congress in the Omnibus Budget Reconciliation Act of 1990 (OBRA '90). In practice, though, the statutory separation is in name only, as it has not brought any concrete separation in the treatment of O&P with respect to the Health Care Finance Administration's (HCFA's) philosophical and financial practices.

The past practice of continuing to group O&P with DME, despite the OBRA '90 recognition of separation, has resulted in confused or limited understanding of this small but important component of rehabilitation.

The President's 1994 budget proposal further confuses O&P and DME by again inappropriately placing O&P's highly specialized patient services with a group of apparatus providers who primarily sell or rent products to support certain treatment modalities.

Congressional Proposals Pertaining to O&P and DME

There are several proposals in Congress that address the fraud and abuse which are believed to be rampant in the delivery of DME products. The organized field of O&P supports these efforts to eradicate fraud and abuse, but does not believe these proposals are applicable to the O&P field, because, as previously discussed, the delivery of O&P patient care service is inherently different from the provision of DME.

Conditions of Coverage

The second area that is crucial for helping to reduce health care expenditures is **conditions of coverage.** To ensure that all Medicare patients enjoy the quality of O&P care, the organized field supports establishing conditions of coverage. While the Medicare billing system was designed to permit fair and equitable reimbursement of O&P devices and services, these codes are used by apparatus providers who do not provide the same product/service combination as O&P practitioners. This has created significant and unintended problems in Medicare reimbursement of O&P services, and may contribute to DME fraud and abuse. Since O&P practitioners are generally not subject to state licensure, O&P provider numbers may be accessed by virtually anyone.

Although O&P practitioners provide health care products and services for which they are highly trained and certified, the Medicare program has no conditions of coverage for O&P services, as it does for similar services, such as those of physical therapists. Such an omission puts the patient at risk through exposure to unqualified practitioners. To address this, the organized field of O&P recommends that conditions for coverage be established under Medicare for the provision of O&P products and services. This measure would serve to promote the quality control of O&P health services provided to Medicare beneficiaries. A definitional standard similar to the one used by HCFA for physical therapists could easily be incorporated into HCFA administrative policies. This measure could be accomplished in the context of the budget proposal.

Such conditions for coverage also compliment President Clinton's goal of investing today, in this case investing in the recognition of quality care, to ensure less expenditure tomorrow. Further, the creation of conditions of coverage for O&P services under Medicare would greatly benefit the Medicare beneficiary as well as HCFA, thereby establishing high standards for quality care.

Conclusion

It is my hope that this testimony has demonstrated that the organized field of O&P has acted responsibly with respect to the delivery of health care and has not contributed to spiralling health care costs, and more specifically, has not contributed to cost spirals that result from DME fraud and abuse. For example, it is important to note that the O&P field: **CAN'T** market artificial limbs and braces through unsolicited telephone calls; **CAN'T** sell unneeded artificial limbs and braces; **CAN'T** engage in carrier shopping; and, **CAN'T** provide unnecessary tests to bilk Medicare. In short, O&P has not used these tactics to gouge Medicare. Therefore, using the typical methods of curbing fraud and abuse in DME inadvertently makes it impossible for legitimate O&P practitioners to recommend devices based on functional necessity rather than just medical necessity. Once again, functional necessity is an investment made today to assure an independent and cost effective future for the physically challenged.

Any attempt to reduce or restrict reimbursement for O&P would adversely impact the profession. To illustrate, increases in reimbursement for O&P practitioners over the last ten years have at times been as low as zero, and never more than five percent. These limited increases in Medicare reimbursement have been difficult to sustain since O&P practitioners have no control over the costs of their components. Should a component increase in cost by 15 percent from manufacturers, the O&P provider can not pass the increase to medicare or the patient, but must cover this increase within the allowed reimbursement amount for the finished product and service.

Finally, because the population that uses these products is so limited, it is impossible to recapture production and research costs through economies of scale, as other products in the marketplace often do. In this regard, O&P has problems similar to orphan drugs.

Quality O&P services, which are investments in rehabilitation/preventive care that save money on expensive treatment in the future, are the next logical step to compliment the American with Disabilities Act (ADA). After all, what good are designated handicapped parking spaces near the food market entrance if an amputee is unable to climb out of the auto and walk to the door?

If the delivery of O&P services is not enhanced, we predict the wisdom of the ADA cannot become a reality. For O&P practitioners to continue providing quality care to its patients, the O&P field must be recognized distinct and separate from DME.

Statement
# of the
American Physical Therapy Association

The American Physical Therapy Association (APTA), which represents over 57,000 physical therapists, physical therapist assistants and students of physical therapy, commends the Subcommittee for holding this hearing and appreciates the opportunity to submit this testimony.

Physical therapists are affected by a number of provisions in the President's Budget Proposal and in other health care legislation which will be before the Committee as part of any Reconciliation package. Our comments include:

- support for the provision to ban physician ownership and referral of physical therapy services;
- support for legislation to eliminate Medicare's $750 annual limit on physical therapy services provided by physical therapists in independent practice; and
- modification of language in the Miscellaneous and Technical Medicare Amendments Act of 1993 to allow greater provider participation in the development of pediatric relative value units.

BAN ON SELF REFERRAL FOR PHYSICAL THERAPY SERVICES

The APTA supports President Clinton's inclusion of a physical therapy self referral ban in his Budget Proposal. However, we believe that the provision does not go far enough because it will permit physicians to skirt the law by converting joint venture operations into employer/employee relationships.

The excess cost to our health care system associated with physicians being permitted to own and self refer patients to physical therapists, laboratories, radiological facilities, pharmacies and other services has been well documented.

In 1989, the Florida legislature mandated that State's Health Care Cost Containment Board examine the impact of joint ventures in health care on the cost of services, quality of services and access to services in Florida. Physical therapy services were surveyed in two settings: free-standing physical therapy facilities and comprehensive rehabilitation centers that provide physical therapy services. The findings were dramatic.

Physician-owned physical therapy facilities provided 43% more visits per patient than did non-joint-venture physical therapy facilities, generating approximately 31% more revenue per patient in joint-venture facilities than in non-joint-venture facilities. At comprehensive rehabilitation facilities, 35% more physical therapy visits were provided per patient in joint-venture facilities, generating approximately 10% more revenue per patient than in non-joint-venture facilities.

Equally important, the Florida study found that quality of care in joint-venture facilities was lower than in non-joint-venture facilities, and that joint-venture facilities did not increase access to services. In fact, the non-joint-venture facilities offered increased access to a wider range of clients. (Higher quality of care and increased access to services are often cited as rationales to defend joint ventures.)

Subsequent to the study conducted in the State of Florida, the Center for Health Policy Studies estimated the impact of physician joint ventures on medical care costs in Florida. This was done for three categories of services: imaging services (MRI and CAT Scan tests), clinical laboratory services and physical therapy services. Estimates for 1991 were developed based on findings from an analysis of Medicare claims data, results from the report by the Florida Health Care Cost Containment Board, "Joint Ventures Among Health Care providers in Florida" and from other sources. The estimated 1991 cost impact of physical joint ventures for these services in Florida are:

•	Imaging Services (MRI tests and CAT Scans) (74% of MRI costs, 16% of CAT Scan Costs)	$322.9 million
•	Clinical Laboratory Tests (16.3% of clinical lab costs)	$167.0 million
•	Physical Therapy Services (2.4% of physical therapy costs)	$10.9 million
	TOTAL	$500.8 million

The cost estimates for clinical laboratory and physical therapy services likely understate the true figures as only additional costs for users of these services were estimated. The incentives for physicians to refer to joint venture facilities likely also resulted in an increase in the number of users, the cost impact of which is not included in the estimates.

Spurred on by the findings of the Florida study, William M. Mercer, Inc. analyzed spending under California's mammoth Workers' Compensation program which will spend an estimated $3.6 billion for medical care in 1992.

The Mercer study found that if an injured worker received initial treatment from a provider with an ownership interest in physical therapy services, that patient received a referral to physical therapy 66% of the time. If, on the other hand, the injured worker received initial treatment from a provider with no ownership interest in physical therapy, the patient was referred to physical therapy 32% of the time.

The study concludes that the added incentive for investing physicians to refer to physical therapy generates approximately $233 million per year in services delivered for economic rather than clinical reasons.

While the President's proposal is a good first step, it contains a loophole which would allow physicians to skirt the intent of the law. The provision would still allow physicians to convert and continue to own physical therapy clinics where the health care staff are employees. This loophole would allow financial interest to remain in the referral process.

The APTA recommends that legislation be enacted to ban this practice of physician self referral to services to which they control access either as a matter of law or third party reimbursement policy. As the law is currently written, physicians are encouraged to offer through their employees the very services which other nonphysician practitioners are licensed by the States to provide but for which a physician's referral is required.

Consequently, if physicians are prohibited from investing in these services, such as physical therapy, but encouraged to offer them through their employees, a significant part of the problem will still remain. The situation will become that those physical therapists who are unwilling to become employees of referring physicians will simply not receive physician referrals and will, therefore, be precluded from providing the services they are licensed to provide.

We urge that Congress repeal Section 1128B(b)(3)(B) of the Social Security Act. This provision of the law protects these very arrangements from being categorized as fraud and abuse situations.

MEDICARE'S $750 ANNUAL LIMIT ON PHYSICAL THERAPY SERVICES

Legislation will shortly be before this Subcommittee to eliminate Medicare's $750 annual limit on physical therapy services that a beneficiary can receive from a physical therapist in independent practice (PTIP). This arbitrary limit is a redundant and ineffective means of utilization control and cost containment because several Medicare requirements already provide adequate protection and control.

Current Medicare coverage guidelines ensure the medical necessity of treatment by requiring that physical and occupational therapy services provided to a beneficiary:

1) be prescribed by a physician;
2) be furnished under a written plan of treatment approved in writing by the beneficiary's physician (the plan must relate the type, amount, frequency and duration of the therapy services and indicate the anticipated goals of treatment. Any changes in the plan of treatment must be approved by the physician); and
3) the beneficiary's physician must review the plan of treatment and recertify the patient's continuing need for therapy services at least every 30 days.

Additionally, the Health Care Financing Administration (HCFA), under the mandate of the Omnibus Budget Reconciliation Act of 1989 (PL 101-239), has placed the services of PTIPs under the physician fee schedule and volume performance standards. This measure controls payment for therapy services by a fee schedule; and overall volume of services are subject to volume performance standards.

Under current Medicare law, there is no limit to physical therapy services when they are provided either in a physician's office or in other provider settings. Medicare only limits coverage for services provided by PTIPs. When a patient who receives services from a PTIP reaches his or her limit, the patient must either stop treatment, change to a therapist in another provider setting, or pay for these services out-of-pocket. Not only is it a burden for older and disabled Americans to change providers, but for those Medicare patients who live in areas where there is a shortage of health care providers such as rural areas,a physical therapist in another setting may be unavailable. Medical necessity and cost containment are ensured by the provisions mentioned above; not by an arbitrary limit of $750. This limit merely disrupts necessary treatment of Medicare beneficiaries.

In the last Congress, Representative Bill Richardson (D-NM) and Senator John Chafee (R-RI), along with 62 of their colleagues sponsored legislation to eliminate the $750 limit. They are preparing to reintroduce this legislation into their respective bodies in the very near future. The APTA asks the Subcommittee to end this burden on older and disabled Americans by rapidly passing this legislation.

EXPAND PROVIDER INVOLVEMENT IN PEDIATRIC RBRVS DEVELOPMENT

The APTA believes that the wording of Section 206 of the Miscellaneous and Technical Medicare Amendments Act of 1993 (H.R. 21) needs to be modified. Section 206 directs the Secretary of Health and Human Services to explore development of a Resource Based Relative Value System (RBRVS) for pediatric services in consultation "with appropriate organizations representing pediatricians and other physicians."

This provision should be amended to ensure that not only physicians, but all health care groups who would be affected by a pediatric RBRVS system are included in the development of such a system.

The APTA supports the development of pediatric resource based relative value units (RBRVUs) because of the inherent differences in the way services are provided to pediatric and adult populations. Pediatric physical therapists deliver a wide range of services to children in schools, homes, private offices, and other community settings. We can be a major resource in the development of physical therapy RBRVUs.

Our concern about being excluded from this process is well founded. HCFA developed RBRVUs for physical medicine codes in the Medicare physician fee schedule with no input from physical therapists. The research team contracted by HCFA decided to solely rely on physician input. The result was a coding system which satisfied neither HCFA nor physical therapists in independent practice, who are required to bill under the Medicare fee schedule. The RBRVUs which were developed were so inaccurate that they were eventually rejected by HCFA. HCFA and the APTA are currently working to develop a coding system which reflects the full scope of physical therapy services and contains equitable RBRVUs. This could have been avoided if we were initially included in the process.

Because any system of codes and values for pediatric services extends beyond physicians to physical therapists as well as other nonphysician providers, the APTA strongly requests that Section 206 be amended by striking "physicians" in the last sentence (page 45, line 24 of H.R. 21) and replacing it with "health care providers."

The APTA appreciates the opportunity to provide this testimony and we are willing to work with the Subcommittee on these and other issues of mutual concern.

Statement Of The

American Society of Anesthesiologists

On behalf of the American Society of Anesthesiologists (ASA), which represents more than 30,000 physicians nationwide, we are pleased to submit the following statement for the hearing record on the Administration's FY 94 budget proposals. We are particularly addressing the so-called "RAP DRG" proposal.

For reasons we cannot understand, the Clinton budget has borrowed an unsuccessful page from the FY88 Reagan budget and proposes to bundle payments for inpatient radiology, anesthesiology and pathology services into the Part A hospital DRG payment. This proposal was a bad idea when the Congress rejected it in 1987. Subsequent enactment of the Medicare Fee Schedule makes it a worse idea today. The projected four year savings are $390 million -- a relatively modest sum to offer as justification for so radical a proposal; indeed, a proposal at total odds with the underlying concepts of the Medicare Fee Schedule mandated by Congress.

The ASA has worked with this Subcommittee over the past several years to achieve significant budget savings. We certainly never welcomed reimbursement reductions but we have been realistic in our assessment of the need for the Congress to find appropriate savings without adversely affecting the quality of anesthesia care. Given this background, we find the Administration's proposal both inappropriate and insensitive: inappropriate because it comes hard on the heels of implementation of the Medicare Fee Schedule under which the specialty of anesthesiology sustained the largest cut of any specialty, and insensitive to legitimate quality of care concerns and to the nature of anesthesiology practice.

To put the RAP DRG proposal in budgetary context, allow me briefly to review the recent history of Medicare reductions for our specialty:

- OBRA '86 ratified HCFA regulations halving the base units for cataract anesthesia services from 8 units to 4 units. Estimated five year savings were $405 million.

- OBRA '87 mandated base unit reductions for those anesthesiologists (70 percent of anesthesiologists) medically directing nurse anesthetists. Estimated three year savings were $35 million.

- OBRA '89 froze anesthesia reimbursement rates and mandated the use of actual anesthesia time, as opposed to rounding up to the next whole unit. Estimated five year savings were $245 million.

- •OBRA '90 cut the average anesthesia conversion factor by 7 percent and extended the base unit reductions for medical direction services. Estimated five year savings were $285 million.

- •The Medicare Fee Schedule, effective January 1, 1992, reduced reimbursement for anesthesia operating room services an average 29 percent upon full implementation -- the largest cut imposed on any specialty.

- •1993 Fee Schedule reduced all physician services another 2.7 percent to achieve budget neutrality for new and revised codes.

In the aggregate, these are dramatic reductions to be placed on one specialty, but to a great extent they have occurred as a result of active good faith give-and-take between ASA representatives and the health committees of the Congress. In part, at least, our cooperation with otherwise unpleasant reimbursement decisions has stemmed from the continuing commitment of the Congress, including this Subcommittee and the full Committee, to the methodology for anesthesia reimbursement advocated by ASA; that is, the use of a relative value guide in which both the procedural and time units are recognized to determine the value of a specific physician service to specific patient.

MEDICARE FEE SCHEDULE AND ANESTHESIA REIMBURSEMENT

One of the reasons Congress decisively rejected RAP DRGs in 1987 was the anticipation of development and implementation of a Medicare Fee Schedule (MFS) based on the Resource Based Relative Value Scale (RBRVS). Many experts, such as the Physician Payment Review Commission, believed that any problems with RAP services would best be addressed through modification of fee-for-service payment for these services.

In the years since 1987, these modifications have occurred via several legislative and regulatory actions which built upon one another and confirmed the commitment of Congress to reimbursing anesthesia services under the Medicare Fee Schedule, using the ASA Relative Value Guide (RVG), and addressing perceived problems with payment levels.

The Omnibus Budget Reconciliation Act of 1987

OBRA '87, which rejected RAP DRGs, mandated that the Health Care Financing Administration (HCFA) adopt a Uniform Relative Value Guide (URVG) for use by all Medicare carriers; this provision had its genesis in this Subcommittee's reconciliation package. Pursuant to notice and comment in the Federal Register, HCFA adopted the ASA RVG as the URVG, for services provided on or after March 1, 1989. An important corollary to this was the adoption of the CPT-4 anesthesia codes, in lieu of surgical codes previously required on claims. The 4200 surgical codes are successfully complemented by only 248 broad anesthesia codes because the addition of anesthesia time measures the difference -- from the anesthetic standpoint -- between the many thousand surgical procedures. I must repeat the specific consideration of actual anesthesia time, makes the use of anesthesia codes valid.

This Subcommittee also included language in OBRA '87 prohibiting any RAP DRG scheme.

Omnibus Budget Reconciliation Act of 1989

Prior to the OBRA '89, anesthesia time was counted and reimbursed in terms of 15 or 30 minute units, with the actual time rounded up to the next whole unit. OBRA '89 contained a significant policy change regarding recognition of anesthesia time -- a change proposed by the Inspector General as a way to achieve accuracy of reimbursement; ASA supported this sound policy approach. Anesthesia time is now recognized in terms of actual minutes or fractional units. This not only achieved budget savings for the Program, but brought tighter verification to anesthesia time.

Most importantly, OBRA '89 also addressed anesthesia services with regard to their integration into the Medicare Fee Schedule. Section 1848(b)(2)(B) of the Social Security Act therefore states:

> In establishing the fee schedule for anesthesia services for which a relative value guide has been established under section 4048(b) of the Omnibus Budget Reconciliation Act of 1987, the Secretary shall use, to the extent practicable, such relative value guide, with appropriate adjustments in the conversion factor, in a manner to assure that the fee schedule amounts for anesthesia services are consistent with the fee schedule amounts for other services determined by the Secretary to be of comparable value.

From our perspective, this statutory requirement for the Department of Health and Human Services to use the Uniform Relative Value Guide for anesthesia services -- in essence, the ASA Relative Value Guide utilizing both base and time units -- is one of the most critical elements of OBRA '89. Members of Congress were instrumental in persuading HCFA not to eliminate anesthesia time units, which would have been contrary to the expressed will of Congress, when the final Medicare Fee Schedule was put into effect. The conference report accompanying H.R. 11 (vetoed in 1992 for unrelated reasons) reinforced the Congressional commitment to preserving actual time.

ASA believes the intent of Congress is both clear and consistent: the Uniform Relative Value Guide, including base units plus actual time, should be the basis for reimbursing anesthesia services under Medicare. With ASA's involvement and support, the Congress over the years has painstakingly crafted its policy on anesthesia reimbursement as part of physician payment reform -- and the Administration's DRG proposal is totally contradictory to that policy. (There would, obviously, be no more RVG or anesthesia time under a RAP DRG scheme.)

THE ADMINISTRATION PROPOSAL HAS FLAWED RATIONALE

According to the Department of Health and Human Services (DHHS) budget, RAP DRGs would give "physicians and hospitals incentives to be cost-conscious, provide only medically necessary services and eliminate the provision of marginal services."

This rationale is seriously flawed. First, and I hope this is self-evident to the Subcommittee, there is no such thing as a "marginal" anesthetic. There is no “marginal service” in the pre-operative evaluation of patients and in the selection, from an array of potentially lethal anesthetic agents, of the appropriate anesthesia plan for an individual patient. There is no marginal service intraoperatively, when the anesthesiologist manages the patient in a carefully controlled anesthetized state, at a medically-determined level between consciousness and death, for a period of time dictated by the surgeon, not by us. Nor is there a “marginal service” post-operatively, when we manage restoration of the patient's respiratory and cardiovascular systems to normal.

Second, the Administration's rationale is inconsistent with demonstrated experience with reimbursement for anesthesia services. A recent study analyzed changes in Part B expenditures between 1986 and 1989 and was published in the Journal of the American Medical Association (JAMA, Holahan and Berenson, 1992). While anesthesia accounted for approximately 6 percent of Part B expenditures, it represented only 2.6 percent of the growth in expenditures. Over the same period, the average annual growth in allowed charges for anesthesiologists was 7.7%, against 12.3% for all physicians.

This data shows only the effects of the fee freeze, OBRA '86 and OBRA '87; the significant impact of the OBRA '90/Medicare Fee Schedule combined 38.7 [average] percent reduction is not even measured at this point. This data also underscores the inability of anesthesiologists to increase volume, or introduce "marginal" services, in response to payment reductions per service.

Concerns stated in earlier years about this specialty -- particularly concerns with low participation rates and significant balance bills -- have been addressed with implementation of the series of reimbursement reductions and imposition of strict balance billing limits. While only one fifth of anesthesiologists accepted Medicare Participating Physician status in 1987 (more than 10 percent below the national average), as of January 1992, nearly one half of anesthesiologists were Participating doctors (less than 3 percent below the national average.) We have every reason to believe that the 1993 participation and assignment rates are even higher. For those who choose not to accept assignment on a given case, the Medicare Fee Schedule allows a balance bill of somewhat less than 10 percent.

Third, to the extent the rationale for RAP DRGs is based on allegedly unnecessary anesthesia procedures, it simply ignores the mechanisms within its own Department which deal with medical necessity issues -- mechanisms which neither HCFA nor the Inspector General are reluctant to use.

RAP DRGs WOULD IMPACT QUALITY OF CARE

ASA believes that the RAP DRG proposal will severely interfere with our direct relationship with patients. The administration proposal will place a third party -- the hospital or entity within the hospital -- between the anesthesiologist and his or her patient. This same concern was cited in a Congressional Research Service paper prepared for the Senate Finance Committee in 1986: "Implementation of a physician DRG system would too closely align the incentives of physicians with hospitals. This might well result in the physician not continuing to be as strong an advocate for needed medical services... " These are valid concerns because DRGs do not pay for services actually provided; in fact, they reward the hospital for services not provided. The hospital incentive will be to limit needed care or to avoid very ill patients in need of surgery.

Even if we lay aside our grave quality of care concerns about such a system, we are deeply disturbed by the concept that we would be providing our service not to the patient, but to the hospital. Anesthesiologists have been practicing as fee-for-service physicians since long before the Medicare Program. While some anesthesiologists may practice under a contractual arrangement with one or more hospitals, these are contracts to assure 24-hour provision of quality services, they are not salary contracts.

Further, the proposal can only address inpatient services. Anesthesiologists provide half their care to outpatients -- what is the rationale for applying two radically different reimbursement mechanisms to services provided in the same operating rooms, but sometimes to inpatients and other times to ambulatory surgery patients?

DRGs ARE NOT RELEVANT TO PHYSICIAN SERVICES

ASA's opposition to the DRG proposal also stems from our deep concern that hospital DRGs do not describe or measure the anesthesia services provided to patients falling within DRGs. What physician DRGs will inevitably represent is a reimbursement system that seeks to "average" medical care within DRG categories that simply were not constructed to account for that care and which, in any given case, will bear no necessary relationship to the services actually provided to a particular patient by the anesthesiologist or, as far as we are aware, by the radiologist, pathologist or for that matter, by the surgeon.

For example, DRG 110 (vascular procedures) would include anesthesia for procedures that vary widely in anesthetic difficulty, from surgery on vessels in the periphery, to surgery for resection of a thoracic aortic aneurysm. These are very different procedures of great variability in difficulty, complexity and skill -- the resource based inputs. The RVG assigns a value of 5 to 8 base units to the former procedures and 20 to the latter, reflecting the significant resource based differences. There are examples such as this for virtually every DRG.

ASA commissioned the Battelle Medical Technology Assessment and Policy Research Center to study the correlation, or lack thereof, between hospital DRGs and anesthesia services. Battelle examined data from 6,300 surgical cases at ten hospitals of varying size and type in five states (summary attached). The Battelle study found the potential for systematic bias within DRGs, with some anesthesia procedures being systematically underpaid, while others were overpaid. Any individual anesthesiologist has neither the volume of cases or control of case mix to mitigate such distortions.

CONCLUSION

The anesthesiologist's relationship with their patients is exactly the same as that of the surgeon: there is a pre-operative exam and evaluation, an intense relationship during the surgery itself, and post-operative care. It is simply incredible that the Administration would seek to treat similar disciplines so incongruously and unfairly.

The ASA cannot speak too strongly against this ill-conceived RAP DRG proposal. If implemented, it would cause serious disruption in patient care, dislocation of physicians and access problems. I can guarantee that physicians would neither stay in, nor enter, anesthesiology as a career if RAP DRGs are approved. This is a critical, demanding specialty with overwhelming implications for patient safety; this cannot be compromised.

We do not ask for special treatment -- if anything, the history of budget cuts shows anesthesiologists have had far more than their share of special treatment. We ask to be treated like all other physicians. There should be no differential updates; if the Congress considers an across-the-board limited MEI update or freeze for all physicians, then that is the appropriate place for anesthesia services. We ask you to forcefully reject RAP DRGs and we ask for your continued support of anesthesia time.

American Society of Internal Medicine
Statement
to the
House Energy and Commerce Committee
Subcommittee on Health and the Environment
for the Record of the Hearing
on
Medicare Part B Budget Issues
March 31, 1993

Introduction

The American Society of Internal Medicine (ASIM) represents 26,000 internists nationwide who provide primary and subspecialty care to Medicare patients. The following are ASIM's views on President Clinton's recommendations on Medicare Part B budget issues.

ASIM's statement will emphasize the importance of working constructively with Congress and the administration in this time of great change. Internists have great anxiety about how they and their patients will be affected by the changes being contemplated. But they also have a great sense of commitment toward achieving workable solutions for their patients. There will be times when ASIM, on behalf of its members, must and will oppose proposals that we believe to be unfair or unworkable. But we prefer to be able to work with Congress and the administration towards achieving consensus on the changes that are needed.

It is in that spirit that ASIM has considered the President's Medicare proposals. You may be hearing from many others who reject out-of-hand the President's recommended changes in Medicare. ASIM is not among them. Instead, on February 24 ASIM wrote to President Clinton and stated our desire to work with him in a constructive manner on his deficit reduction plan. There are some proposals in the plan that ASIM supports, such as the proposed exemption from cuts for some visit services.

Although ASIM supports appropriate measures to allow for deficit reduction and expanded access, internists are concerned that continued cuts in Medicare will compromise their ability to provide patients with appropriate care. Too many cuts, especially if targeted at the wrong expenditures, could be highly detrimental to Medicare patients. Consequently, ASIM's support of the administration's and Congress's efforts to reduce the rate of increase in Medicare expenditures is predicated on the following principles:

1. **Savings in Medicare should not be allocated solely to deficit reduction, but also to expanding access to health insurance coverage.** Internists will be far more willing to accept limits on Medicare spending increases if they perceive that the savings will be used to expand health insurance coverage for those who are now unprotected, rather than solely to reduce the deficit or to allow for increased spending in areas other than health.

2. **Services that are already underpaid--and that are experiencing access problems as a result--should not be subjected to further Medicare cuts.** Instead, savings should be achieved from other services that are paid too high, and where there is little risk of access problems being created if payment increases are restrained.

3. **Efforts to limit increases in Medicare spending on physician services should be part of a balanced package that also asks beneficiaries, taxpayers, suppliers, and others in the health industry to also do their part to reduce the deficit and expand access.** Physicians should not be singled out for an unfair proportion of the Medicare savings that will be required to reduce the deficit and expand access to care.

4. **Specific changes in authorizing legislation that are needed to achieve the savings goals must be carefully scrutinized, prior to enactment, to assure that they do not result in further "micromanagement" of physician practices or result in denial of payments for legitimate services.** In 1990, when Congress and the President last reached agreement on a major deficit reduction package, the result was enactment of several provisions that denied payment for legitimate services. A last-minute addition to the OBRA 90 Medicare spending cuts resulted in elimination of payments for EKG interpretation, which has disrupted the ability of physicians and hospitals to arrange for qualified interpretation of this important diagnostic test. OBRA 90 also included unfair limits on payments to new physicians. It is essential that Congress not only correct these mistaken policies, but that care also be taken so that similar mistakes do not occur this time around.

For the most part, ASIM believes that President Clinton's Medicare proposals are consistent with the above principles. The package exempts certain undervalued primary care services from the proposed cuts, targets most of the reductions toward services that have been paid too highly, requires each of those with a stake in Medicare--physicians, hospitals, durable medical equipment (DME) suppliers, and taxpayers--to contribute toward the savings, and generally avoids proposals that would result in micromanagement or denial of reimbursement for legitimate services. It appears, however, that all of the Medicare savings will be devoted to deficit reduction, not expanded access. And ASIM remains concerned that the balance struck in the package may be altered in Congress as other groups oppose cuts that adversely affect their interests.

I'll now share with the subcommittee ASIM's specific views on the President's Part B Medicare proposals.

The Medicare Budget and Primary Care

ASIM specifically supports--and commends--the President for proposing that primary care services be exempted from the proposed reduction in next year's fee schedule update. Under the proposal, primary care services (which in the past has been defined in statute as office, nursing home, and home visits) would in 1994 receive the *full* fee schedule inflation update required under current law. All other services would receive the current law update minus two percent. If enacted by Congress, this would represent the first time in three years that some primary care services received an update that is at least equal to inflation. The 1993 update, by comparison, was only .8 percent for visits and other nonsurgical services but 3.1% for surgery.

Exempting primary care from further cuts would be an important first step toward alleviating the growing crisis in access to primary care. In March, ASIM released a major new white paper "Rebuilding Primary Care: A Blueprint for the Future." The paper explains why primary care is in trouble, and what can be done about it. A copy of the paper has been sent under separate cover to the members of this subcommittee.

There are a few key issues raised in the paper that apply directly to the subcommittee's consideration of Medicare budget issues.

In reviewing the research literature to prepare the paper, ASIM found that the number and proportion of physicians in primary care has been steadily declining. Even more disturbing, the trend is getting worse. Citing numerous studies, the paper reports that:

- The proportion of physicians who are in the primary care specialties of internal medicine, pediatrics, and family practice has declined from 50 percent in 1963 to only 34 percent today.

- Only 14 percent of medical students surveyed in 1991 intend to go into primary care.

- If current trends continue, within a decade fewer than 20 percent of America's physicians will be in primary care.

- Costs will be lower and care will be better if there is a greater number and proportion of internists and other primary care physicians.

- The principal factors driving physicians away from primary care is a hostile economic and regulatory environment and a training system that encourages overspecialization.

The paper provides 44 specific and detailed recommendations for rebuilding primary care. Because Medicare has a disproportionately larger impact on internists than other payers, 18 of the recommendations are for changes in Medicare's payment and regulatory policies.

One of the key recommendations is that primary care services should be protected from further budget cuts. The paper notes with approval President Clinton's proposal to exempt office, nursing home, and home visits from the reduction in next year's update. But the paper also cautions that as groups raise objections to other Medicare cuts, the higher update for primary care that the President proposes could be at risk of being reduced. This would occur if Congress rejected some of the cuts and made up the lost saving by lowering the primary care update.

You are likely hearing from some of the other groups that a "more fair" alternative to the administration's proposed cuts would be for Congress to enact an across-the-board limit, freeze, or delay in the 1994 Medicare fee schedule update. ASIM strongly disagrees.

Nothing could be *more unfair* than freezing in place a payment schedule that undervalues primary care and other visits services and that pays too much for many other services, or in delaying the update for primary care services. If, in order to ease the cuts in other areas, office, nursing home, and home visits are not given the full update proposed by the administration, it will be yet one more signal that the federal government is not yet willing to take the steps needed to begin to rebuild primary care. By doing so, the trend away from primary care will be exacerbated.

ASIM believes that the administration was right to recognize that if additional Medicare savings are needed, they should come from non-visit services that are being paid more highly, and for which there is no evidence (unlike primary care) that patients are likely to experience problems in obtaining access to those services even if further payment increases are limited. We urge the subcommittee to uphold this approach by providing a full 1994 fee schedule update for office, nursing home, and home visits, and to reject the calls that will be presented under the guise of "fairness" for an across-the-board freeze or delay in the 1994 fee schedule update.

We do believe that there is one key element of the administration's proposal that requires clarification, however. The administration proposes that primary care receive the "current law" update, and that all other services would receive the "current law" update minus two percent. This has been reported to mean either that primary care would receive the full Medicare economic index (MEI), and other services the MEI minus two percent, or that primary care would receive the MEI plus or minus actual expenditure performance relative to the nonsurgery volume performance standard (VPS), and all other services would receive the MEI plus or minus actual expenditure performance compared to the applicable VPS, minus two percent. Preliminary expenditure data reportedly indicate that expenditures for both surgery and nonsurgery fell under their applicable VPS. If this is the case, the current law update for surgery and nonsurgery would be the MEI plus an (as yet to be released) bonus payment. It has also been reported that expenditures on surgical procedures may have come under the applicable VPS by a larger margin than nonsurgery, which would mean that under current law surgery would receive a larger bonus than nonsurgery.

A higher current law "bonus" for surgery could result in the surgical update being equal to or even higher than the primary care update, even after the two percent reduction for non-primary care services that is proposed by the administration. ASIM would strongly object to an update for surgery that is higher than that for primary care. In establishing the surgery VPS, the administration assumed that a behavioral offset would occur to offset fee reductions under the RBRVS, when preliminary analyses by the PPRC and others suggest that such an offset may not have occurred after all (or at least not to the degree projected by HCFA's actuaries). Consequently, even if surgical expenditures fell below the surgery VPS by a greater margin then nonsurgery, this is likely due to HCFA's erroneous assumption of a behavioral offset in developing the surgical VPS, not because of better performance by surgeons in controlling volume.

We strongly recommend that the subcommittee seek clarification from the administration of its proposal to provide a full update for primary care and the current law update minus two percent for all other services. If the administration's proposal would result in a higher update for surgery than primary care, even after application of the two percent reduction, ASIM recommends that the subcommittee modify the proposal to provide a higher absolute update for primary care than for surgery, which we believe is the real intent behind the administration's proposal. And, under this scenario, if additional savings are needed because other proposed Medicare cuts are rejected by the subcommittee, they should come out of the surgery update, not primary care. If Congress is to begin to rebuild primary care, it is essential that primary care receive higher updates than surgery, especially given the fact that the update last year for primary care was significantly lower than for surgery.

Finally, the payment inequities that were created last year by the separate VPSs for surgery and nonsurgery, and that could occur again in 1994, point out the urgent need to modify the VPS mandate to create incentives for primary care visits and other E/M services.

Modifying the Volume Performance Standards

The administration also proposes to lower the "default" volume performance standards (VPS). ASIM supports the need to amend the VPS formula established by OBRA 89 and 90. As the subcommittee may be aware, ASIM urged Congress last year to amend the formula to preclude the separate and higher update for surgery--and the lower update for all nonsurgery, including primary care--that occurred in 1993 based on the existing statute. Unfortunately, Congress adjourned without taking any action to prevent the higher default update for surgery from going into effect. The result is that unless Congress acts to correct the problem, surgery will permanently have a higher conversion factor than nonsurgical services, including primary care visits and other evaluation and management (E/M) services.

The administration's proposal provides an opportunity to correct this flaw. Instead of lowering the default VPS equally for surgery, nonsurgery, and all services, as the administration's proposal apparently would do, ASIM instead urges that the subcommittee either support a single VPS for all services, or that it work toward establishment of a separate and higher VPS for E/M services and a higher default update for office, nursing home, and home visits. Specifically, if separate VPSs are to be maintained, Congress should:

- Amend OBRA 89 and 90 to establish a separate and higher VPS for evaluation and management services, including primary care visits. For E/M services only, the VPS should be based not only on historical expenditure trends, demographics, changes in law, and an "intensity" factor, but also on an explicit factor that is designed to allow for investment of additional spending on E/M services.

- Amend OBRA 89 and 90 to raise the default "floor" on the fee schedule update for office, nursing home, and home visits ("primary care" services) only. The current floor (minimum update) for all services is the Medicare economic index minus 2 percent. For the specified visit services, the floor could be raised to the MEI, or the MEI minus .5 percent, thus assuring that primary care would be protected even if spending exceeded the VPS for those services.

- If necessary to allow for a higher default VPS and update for E/M and primary care services and still maintain the savings expected under the President's proposal, the default VPS and update for all other services should be set at an even lower level than the administration proposes.

In its 1993 report to Congress, the Physician Payment Review Commission (PPRC) proposed similarly that if separate VPSs are to be maintained, E/M services should be given improved treatment by being placed under a separate VPS.

Implementation of Resource-Based Practice Cost RVUs

The administration proposes to begin phasing in resource-based relative value units (RVUs) for services paid under the Medicare fee schedule. ASIM has been on record for several years as favoring a change in the OBRA 89 methodology for determining the practice expense RVUs under the Medicare physician fee schedule. The existing method, by basing practice expenses on historical charges instead of resource costs, perpetuates inequitably high payments for surgery and other services done primarily in the hospital setting, and unfairly low payments for E/M services. We are pleased that the Physician Payment Review Commission in its 1993 report recommended that Congress mandate implementation of a resource based practice cost methodology.

Although the administration's proposal also would begin moving toward a resource based methodology, it apparently would do so in a manner that would lower the practice expense RVUs for some overpriced services, without raising them for other services--especially E/M services--that the PPRC believes are underpaid under the current formula. Under the administration's proposal, by obtaining savings from interim reductions in the RVUs for overpriced services, but without increasing them for undervalued ones, there would be little or no money available to raise the practice expense RVUs for E/M services when a full resource based methodology is implemented in later years. ASIM believes that it would be highly unfortunate for a resource based practice cost methodology to be used only as a budget-cutting tool, rather than one that also results in more equitable payment for undervalued E/M services as intended by the PPRC, ASIM, and others that have supported this concept.

ASIM believes that Congress and the administration should consider an alternative that would allow for interim increases in the practice expense RVUs for E/M services, while also obtaining some short-term budget savings. The administration proposes to reduce the practice expense RVUs for all services whose current practice expense RVUs exceed their work RVUs. The practice expense RVUs would be reduced each year by 25 percent of the difference between the current work RVU and the practice expense RVU, subject to a floor (maximum reduction) of 110 percent of the work RVU. The alternative that we believe should be considered would accelerate the reduction in the practice expense RVUs for overpriced services, and lower the floor on the maximum reduction that would be permissible, with all of the additional savings being used to raise the practice expense RVUs for undervalued E/M services, especially office visits. The practice expense RVUs for overpriced services, for example, could be reduced each year by 33 percent (instead of 25 percent) of the difference between the work and practice expense RVUs, and the floor (maximum reduction) lowered to 100 percent of the work RVU, with the additional savings used to begin phasing in higher practice expense RVUs for office visits and other E/M services. ASIM also believes that the administration should publish for comment the specific services that would be reduced under its proposal, and the amount of the reduction, to allow for individuals to comment on the appropriateness of reducing the practice expense RVUs for specific services.

Another option the subcommittee could consider would be to begin phasing in higher practice expense RVUs for office and other visits, and paying for this by lowering any "bonus" update for surgical procedures that might occur under current law (even after the administration's proposed two percent reduction), as discussed earlier. This might eliminate the need to accelerate the reductions in overpriced practice expense RVUs and to lower the floor on the maximum reductions that could occur.

Regardless of which alternative is selected, ASIM urges the subcommittee to instruct the administration to begin phasing in a resource based practice expense methodology in a manner that provides for increases in the practice cost RVUs for undervalued E/M services, while maintaining the proposed budget savings if necessary.

Laboratory Fee Schedule Reductions

The proposed cuts in the Medicare laboratory fee schedule are of concern to internists, many of whom are struggling to keep open their office laboratories at a time when their costs are increasing due to the requirements of the Clinical Laboratory Improvements Act (CLIA). We believe that the administration and Congress should reassess the impact of those cuts on the ability of primary care physicians to provide their patients with quality laboratory testing. If it turns out that many physicians are in fact being forced to close their laboratories due to the high costs of complying with CLIA and lower Medicare payments, Congress should consider modifying the administration's proposal to allow for payments that are sufficient to cover the costs that physicians incur in providing their Medicare patients with the convenience of an in-office lab. To allow for Congress to make an informed judgement, ASIM recommends that Congress require HHS to study and report annually to Congress on changes in the number of labs operated by physicians and the impact on beneficiary access to those services, including an assessment of the impact of costs of complying with CLIA and reduced laboratory reimbursement on availability of in-office laboratory testing.

Self-referral Legislation

The administration also proposes to extend the ban on physician "self-referrals" to facilities other than laboratory services. ASIM supports further restrictions on potentially abusive self-referrals, provided that "shared" laboratories are exempted (shared laboratories are office laboratories that are shared by several physicians to provide testing for their own respective patients, usually located in space contiguous to their offices, but who do not otherwise meet the definition of a group practice), since such shared arrangements are often the only way that many physicians can afford to maintain a lab for their patients. Such an exemption was contained last year in H.R. 11, which was vetoed by President Bush, and has been re-introduced as part of H.R. 21, introduced by Rep. Dan Rostenkowski (D-IL). Since the Department of Health and Human Services (HHS) does not believe that it has the authority to grant a regulatory exemption for shared labs, it essential that Congress promptly enact H.R. 21. New self-referral legislation should also continue the current exemption for in-office diagnostic procedures, such as office X-rays, that are an essential part of a physician's practice.

Electronics Claims Processing

ASIM supports the goal of converting to electronic claims processing. Physicians should not be penalized, however, if they are unable to convert to electronic claims processing because of a lack of administrative and technical assistance from Medicare or for other legitimate reasons, such as excessive costs. ASIM strongly believes that the administration must assure that sufficient technical expertise is provided to physicians to facilitate conversion by 1996. Congress should reexamine prior to implementation the administration's proposal to begin charging $1.00 per paper claim, starting in 1996, if it appears that physicians have not been provided with sufficient assistance in making conversion to electronic billing, or costs and other factors have precluded a substantial number of primary care physicians from making the conversion by 1996. HHS should be required to report to Congress, no later than June, 1995 on the technical assistance that has been provided to physicians, and the number of physicians who have--and have not--converted to electronic claims processing. The $1.00 per claim "penalty" should be postponed if this report shows that a significant number of physicians have been unable to convert to electronic claims processing.

Other Part B Cuts

This statement has focused on those Medicare proposals in the President's plan that will have a direct impact on internists and their patients. We recognize that some of the other organizations testifying today will express strong objections to some of the proposed cuts. There may in fact be legitimate reasons for some of their objections. The subcommittee has a responsibility to consider legitimate concerns about the President's proposals, and to consider modifications if necessary. But if some of other proposed Medicare cuts are rejected or modified, it is essential that the "lost" savings not be made up by lowering the update for office visits, nursing home, and home visits. As stated above, ASIM will strongly oppose any effort to provide for a lesser update for office, nursing home, or home visits ("primary care services"), in order to allow for proposed cuts in other areas to be restored.

Conclusion

Even with the proposed full update for office, nursing home, and home visits, the President's proposals will require sacrifice from internists. Many of their other services will receive a less-than-inflation update, payments for laboratory services will be curbed, and payments for some services may even be reduced as a resource based practice expense method is phased in. Nevertheless, ASIM is willing to work constructively with the President and Congress on restraining increases in Medicare expenditures, as part of a balanced and fair package to reduce the deficit and expand access to care. We believe that our suggestions for modifying the volume performance standard (VPS) and default update, and for changes in the administration's proposal to implement a resource based practice expense methodology, would further the goal of rebuilding primary care while still allowing for savings.

ASIM has also suggested that some of the other proposed cuts be reexamined based on further data. We have suggested that HHS be required to report on changes in the number of physicians who offer in-office laboratory services, and if the data show that physicians are unable to maintain their office labs under the proposed laboratory fee schedule cuts and given the costs of complying with CLIA, reexamination by Congress of those cuts would then be in order. Similarly, the proposal to begin in 1996 charging $1.00 per paper claim should be reexamined prior to implementation if physicians have been given insufficient technical assistance or other legitimate factors have precluded large number from converting to electronic claims processing.
ASIM also urges Congress to require that some of the Medicare savings be used to expand access, rather than solely for deficit reduction.

As long as the proposed package remains true to the principles outlined at the beginning of this statement, ASIM will not oppose further savings in Medicare. To recap, ASIM believes that Medicare savings must be used not only to reduce the deficit, but to expand access; that primary care and other undervalued services must be protected from cuts; that the package must require a fair and balanced contribution from all players, as the administration's proposal appears to require (rather than physicians being singled out for disproportionate cuts); and the savings must not be achieved through policies that would micromanage physicians practices or result in denial of payment for legitimate services. By and large, and notwithstanding ASIM's recommendations for modifying specific administration proposals, the President's package is consistent with these principles. We urge the subcommittee to act to assure that the final package that is enacted by Congress does not depart from them.

Finally, ASIM urges the subcommittee to consider other legislative changes to assure adequate access to services by internists, especially primary care internists. Exempting primary care from further budget cuts will not, by itself, encourage physicians to enter and remain in primary care (although further cuts would certainly *discourage* them from doing so). ASIM urges the subcommittee to consider the other proposals in "Rebuilding Primary Care: A Blueprint for the Future," many of which fall under the subcommittee's jurisdiction. Protecting primary care from further cuts is a step in the right direction. But much more must be done to alter an economic, regulatory and training environment that is hostile to primary care.

STATEMENT OF THE

ASSOCIATION OF FREESTANDING RADIATION ONCOLOGY CENTERS

The Association of Freestanding Radiation Oncology Centers ("AFROC") is delighted to have the opportunity to submit this testimony with respect to the Medicare Part B provisions of the federal government's FY 1994 budget. AFROC is an association of over 150 freestanding radiation oncology centers located throughout the country. Freestanding radiation oncology centers are health care facilities organized and operated to provide high quality, cost-efficient radiation oncology services to patients in their communities outside the hospital setting. It is estimated that there are approximately 300 to 350 freestanding radiation oncology centers located throughout the country, most of which are owned by the radiation oncologists who provide professional services in the facilities. Freestanding radiation oncology centers are heavily dependent on Medicare reimbursement, since approximately 55 to 65% of patients treated by such centers are covered under the Medicare program.

AFROC's comments relate specifically to proposed reductions in Medicare payment for practice expenses and proposed restrictions on physician "self-referral" for radiation oncology services. Each of these issues is discussed separately below.

I. PROPOSED REDUCTIONS IN MEDICARE PAYMENT FOR PHYSICIANS' "PRACTICE EXPENSES."

The provision of radiation oncology services outside the hospital setting requires significant capital investment, and the ongoing operation of such centers entails high expenditures for specialized staff, equipment, equipment maintenance, and other "facility" costs. In effect, such costs are comparable to the "facility costs" incurred by hospital outpatient departments that provide the same services.

Such "facility" costs are not directly reimbursed by the Medicare program; rather, these "facility" costs are currently reimbursed as the "technical" component of radiation oncologists' fees, under Medicare's physician fee schedule. When the Health Care Financing Administration ("HCFA") implemented the physician fee schedule, it closely analyzed the technical component RVUs provided for radiation oncology services, at the request of AFROC and other concerned radiation oncology organizations. Specifically, HCFA analyzed two cost studies that were submitted by the industry (one of which was performed by AFROC) and concluded that, in fact, freestanding radiation oncology centers had been underreimbursed for the substantial "facility" costs involved in providing radiation oncology services in freestanding settings. As the result of its analysis, HCFA decided to adjust the technical component RVUs provided for radiation oncology services to more accurately represent the costs incurred by "efficiently operated" facilities. Thus, the technical component RVUs for radiation oncology services are among the only technical component RVUs that are specifically based upon the resource costs involved.

In its proposed budget, the Administration has suggested that practice expense RVUs for certain services be reduced to more accurately reflect the resource costs involved. AFROC respectfully requests that radiation oncology technical component services be exempt from any such reductions, since the technical component RVUs for these services have already been adjusted by HCFA to reflect the substantial resource costs involved in providing radiation oncology services in freestanding settings.

II. PHYSICIAN "SELF-REFERRAL."

The President's budget proposal also proposes to extend the current restrictions on clinical laboratory "self-referral" to a number of other services, including radiation therapy services. AFROC strongly believes that where referring physicians, such as medical oncologists and surgeons, have a financial interest in a radiation therapy facility, this financial interest presents a serious conflict of interest which may interfere with the referring physician's judgment concerning the most appropriate center for the provision of radiation oncology services. For this reason, AFROC strongly supports the extension of physician "self-referral" restrictions to providers of radiation therapy services.

However, great care should be taken to ensure that such legislation does not inadvertently preclude radiation oncologists from owning their own facilities. For example, some of the bills introduced to extend restrictions on physician "self-referral" to radiation oncology and other "designated health services," fail to make conforming changes in the physicians' office exception included in the legislation. If the physician "self-referral" restrictions currently applicable to clinical laboratories were to be extended to radiation oncology services without appropriate changes in the exception language, the legislation could be read to preclude radiation oncologists from owning their own office. AFROC does not believe that radiation oncologists' ownership of their own facilities raises the types of conflicts of interest issues raised by medical oncologist or surgeon ownership of these facilities, nor do we believe that the "self-referral" legislation was originally intended to preclude radiation oncologists from owning their own facilities. Accordingly, we request that any physician "self-referral" legislation include a specific exception for radiation oncologist-owned centers.

If you have any questions regarding this testimony or any other questions concerning AFROC, please do not hesitate to call AFROC's Washington counsel, Diane S. Millman, at (202) 778-8021.

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Statement of

The College of American Pathologists

The College of American Pathologists appreciates the opportunity to share with the Subcommittee pathologists' perspective on Medicare Part B budget proposals. The College represents more than 13,000 physicians who practice laboratory medicine in community hospitals, academic medical centers, independent medical laboratories, and other settings in which Medicare patients are provided necessary medical services.

At the outset, we would like to acknowledge that physicians should be involved in and contribute to the effort to control federal spending for health care services. The College of American Pathologists is willing to work with the Subcommittee in that regard. We are not asking to be exempt from those efforts. We do ask that pathologists' share of the efforts to control health care spending be appropriately structured, that it not be disproportionately large given the size of the specialty, and that it not be crafted in such a way that the future of pathology and the quality of laboratory medicine will be endangered.

In the Administrations' budget plan are several proposals that would affect pathologists. The College statement focuses on six of those items.

I. Bundling Inpatient Pathology, Radiology, and Anesthesia Payments

Once again an Administration has proposed bundling Medicare payments for pathology, radiology, and anesthesia services provided in the hospital setting into a fixed payment per discharge. The payment would be made not to the physicians who provide the services but to the hospital or the medical staff. In 1987, after extensive study and debate, the Congress rejected a virtually identical proposal. Since then, the Congress has adopted a resource-based fee schedule for pathology and other physician services. We urge you to reject the bundling proposal.

The Administration's proposal asserts that the bundling proposal would give physicians and hospitals the incentives to be cost-conscious, provide only medically necessary services, and eliminate the provision of marginal services. We can think of no manner in which the bundling proposal would accomplish this. Instead, hospitals and physicians would be unfairly burdened by federal requirements imposing new relationships among them, a burden which would be destructive to development of voluntary collaborative arrangements at the local level that could serve to contain the growth in health care costs while preserving the quality of and access to health care services.

The College believes that the interests of the government, of patients, and of physicians as patient advocates are best met when payment for physician services is made to the physician who provides the service without mandated intervention of another party, such as a hospital or medical staff. The College also believes that decisions about the relationships between hospitals and pathologists and pathologists and other physicians are best handled at the local level, so they can respond to local health care needs and local market conditions. Micro-management of local relationships between health care providers by the federal government will only harm physician-to-hospital, physician-to-physician, and physician-to-patient relationships and over time erode the quality of health care.

Pathologists, and all other specialties, are already very actively engaged in development of innovative collaborations and networks of health care service delivery that only a few years ago had not been contemplated. Those efforts vary in structure and size from region to region, of necessity having been structured to meet the needs of the local area. We urge the Subcommittee to allow those types of voluntary and very competitive efforts to continue and not to dampen such efforts by imposing a new federal structure for payment of pathology services.

II. RVS Fee Schedule Update For 1994

The Administration's proposal would give a Medicare relative value scale fee schedule update for 1994 of approximately two percentage points less than the full update that would otherwise be allowed, with a full update only for primary care services.

The College is willing to work with the Subcommittee and Congress to discuss a reduced RVS fee schedule update for 1994 as physicians' contribution to attempts to reduce health care spending and to reduce the budget deficit. There is no sound basis for subjecting pathology to a more onerous reduction than is applied to physicians in general. Instead of imposing a bundling initiative for pathology services, we urge the Congress to include pathology in whatever update or reduction is generally applied to physicians for 1994 using the payment system that is currently in place.

III. RVS Practice Expense Component Reductions

The Administration's proposal also includes a reduction in 1994 through 1996 of the practice expense relative value components in the Medicare RVS. Our understanding is that the basis for this proposal is the Physician Payment Review Commission recommendation that the Health Care Financing Administration conduct studies to allow resource-based practice expense relative value units to be phased-in beginning in 1997.

The College is not opposed to resource-based practice expense components. In fact, the College has been proactive in the development of resource-based components by funding an external study of the practice expenses incurred by pathologists in the provision of services subject to the Medicare relative value scale. Those data now form the basis of the pathology technical component values.

We do oppose arbitrary changes in the Medicare practice expense relative values prior to completion of studies suggested by the PPRC. The Medicare RVS is only in its second year of implementation. Confusion, misunderstanding, mistakes, and other implementation problems are still in the process of being resolved. Yet another change in a fundamental part of the RVS fee schedule, the practice expense components, would be unfair to physicians and confusing to all involved. The College urges you to allow the relative value practice expense components to go unchanged until a time when more accurate data on what they should be are available.

IV. Reductions in Payment for Clinical Laboratory Services

The budget proposal includes a provision to reduce national caps on the Medicare clinical laboratory fee schedule from 88% to 76% of the national median of the carrier-specific fee schedules. Apparently there would be some potential for differential adjustments.

Since its beginning in 1984, the Medicare clinical laboratory fee schedule has been a favorite target for budget reduction efforts. Attached is a summary of the reductions and other changes in the fee schedule over the past nine years (Attachment A). This history alone should give pause to any proposals for additional reductions for these services. The current proposal is additionally troublesome because of its size — reduction from 88% to 76% is a dramatic reduction that the College must oppose, because it would drive many small laboratories out of the market and reduce local access to these services.

However, it has been sometime since the clinical laboratory fee schedule has been looked at other than as a budget saver. The College would appreciate the opportunity to work with you to resolve some glaring inequities in payment for certain services subject to the clinical laboratory fee schedule. We are also willing to discuss reductions in payment under the fee schedule.

In particular, the Medicare payment policy for Pap smear testing of women is totally contrary to federal attempts to ensure the quality of Pap smears and to encourage Medicare beneficiaries to avail themselves of this benefit. In 1988, the Congress passed the Clinical Laboratory Improvement Amendments which established stringent new requirements and restrictions on the provision of cytology services, especially Pap smears. Personnel requirements, workload restrictions, proficiency testing quality assurance mandates, and other CLIA '88 requirements have greatly increased the cost of Pap smear screening. The following year, in 1989, the Congress recognized the importance of the Pap smear as a preventive health care service and added to Medicare benefits a provision for reimbursement of a screening Pap smear every three years or more often for women at high risk of developing cervical cancer. The 1989 provision explicitly provided for coverage of both the screening by a technologist and a physicians' interpretation when medically necessary.

Nevertheless, Medicare payment for the technologists' screening service under the clinical laboratory fee schedule was capped nationwide in 1992 at $7.89, well below the cost of this service. Information from cytology laboratories indicates that the cost of the screening Pap smear is somewhere between $10 and $20.

In addition, with implementation of the Medicare relative value scale, the Health Care Financing Administration arbitrarily and without opportunity for public comment eliminated separate payment for physician interpretation of outpatient Pap smears. Pathologists are required under CLIA to review and diagnose all abnormal Pap smears. Prior to 1992, the Medicare program made separate payment for these interpretations. The pathologists' Pap smear interpretation was studied by Harvard during the relative value studies and a relative value has been established for the service on that basis. Were the Medicare relative value scale fully implemented, and using the current $31 conversion factor, the average payment nationwide for a pathologists interpretation of a Pap smear would be about $25.

The Administration's policy regarding Pap smear interpretations is that payment for the interpretation is included in payment for the technologists' review under the clinical laboratory fee schedule, beginning January 1, 1992. However, the clinical laboratory fee schedule payment was not increased to include payment for these intterpretatios. Instead, beginning last year the $7.89 cap, already well below the cost of Pap smear screening, was merely deemed to now include payment for a pathologists' interpretation.

Clearly this is a problem from several perspectives. First, the payment for the technologists' review is inadequate for the services that it has been intending to cover since 1984. If indeed there ever was any payment in the clinical lab fee schedule for pathologists' interpretations it was not on the basis of resources as those data were not available until the Harvard studies were completed. The Medicare relative value for the interpretation of a Pap smear is the federal statement of the resources involved in pathologists' interpretation of Pap smears, not the Medicare clinical laboratory fee schedule. In addition, pathologists in hospital practices generally do not receive the clinical laboratory fee schedule amount at all; that payment goes to the hospital. As discussed above in another context, we strongly believe that it is in the best interest of the government, physicians, and patients for Medicare payment for physician services to be made to those who provide the services not to another party.

The College is willing to work with the Congress and the Administration to discuss reductions in national caps for clinical laboratory fee schedule services, including differential adjustments, with the provision that problems with the payment policy for Pap smears be corrected.

V. Physician Ownership, Referral, and Direct Billing

The Administrations' proposal includes an extension of the current Medicare prohibition on ownership and referral arrangements for clinical laboratory services to additional services. Several bills have been introduced to address those issues and to extend the prohibition to all payers.

Consistent with American Medical Association policy, the College of American Pathologists supports limitations on self-referral. The College believes, however, that prohibitions on physician ownership and referral arrangements must, in order to be equitable and effective, create a level playing field. That is, there should not be exemptions for certain types of services that will produce distortions in the market and adversely affect the quality of those exempt services.

The current Medicare prohibition on self-referrals went into effect on January 1, 1992, and applies to all clinical laboratory services, including tissue pathology and Pap smears. We are concerned about proposed exemptions to the prohibitions on self referral in H.R. 21 and H.R. 345 for interpretation of tissue pathology, Pap smear slides, and the provision of other cytology services. Prohibitions on self referral should include tissue pathology and cytology services as well, to assure that there is a level playing field in arrangements for these services. The College urges that the current Medicare prohibition on self-referrals for clinical laboratory services, including tissue pathology and Pap smears, be retained and included in proposals to expand self-referral prohibitions to all payers.

In addition, the College firmly believes that a direct billing requirement goes hand-in-hand with prohibitions on self referral. Since 1984 there has been a direct billing requirement for services under the Medicare clinical laboratory fee schedule (clinical diagnostic laboratory testing). Payment can be made only to the entity that provides the services, with an exception for referrals between laboratories that are independent of a physicians' office. Physician pathology services subject to the Medicare relative value fee schedule are not subject to this requirement. For those services, an ordering/referring physician can purchase the service from pathologists and bill the Medicare program themselves, although they have not provided the service.

The College urges the Congress to expand the direct billing requirement for Medicare to pathology services subject to the Medicare relative value scale, and in any legislation that expands self referral prohibitions beyond Medicare to include a direct billing requirement for anatomic and clinical laboratory services.

VI. Graduate Medical Education Payments

The Administration's budget proposal would change Medicare payment policy for direct Graduate Medical Education such that payment would be based on a national average per resident amount and would give greater weight to primary care residencies.
The College of American Pathologists appreciates the need to ensure adequate access to primary care services through incentives for medical students to enter those areas of medical practice. We want to make you aware, however, of a growing problem in recruitment and retention of pathology residents, and of the implications of that problem for an adequate supply of pathologists in the near future. Any differential weighing of specialty residency programs should be based on a study of the need for residencies in each specialty, not an across-the-board reduction in non-primary care funding.

Pathology is not a large specialty, despite the fact that pathologists' services are required in almost every hospital setting and are considered an essential component of medical care in all communities. The American Medical Association listed fewer than 1000 pathologists in 1940, the first year that such data are available. As with other specialties, in the years following World War II pathology experienced a growth in the number of medical students entering the specialty. Even so, the proportion of physicians who are pathologists reached a peak of only 3.1% in 1970 and has declined since then. Likewise, the number of pathology training programs in Graduate Medical Education has steadily declined since the late 1960's from over 600 to 200.

We are now in the period during which pathologists who trained and entered practice following World War II are leaving practice. Pathologists currently practice 25 to 30 years. Average age at completion of residency training is 34 years; average age at retirement is 62; and there is an average of 6.86 deaths per 1000 pathologists per year. We anticipate that one third of the pathologists who entered practice between 1940 and 1965 will have reached retirement age by 1994. The specialty is losing an average of 1.87 pathologists per day.

In contrast, problems in recruitment and retention of pathology residents are producing an average of only 0.96 newly trained pathologists per day. Attrition is a significant problem in pathology - approximately 30-40 percent of pathology residents fail to finish training. When the 25% of pathologists who pursue careers in academic pathology, the military service, forensic and government jurisdictions, and industry are eliminated, this leaves less than 400 new pathologists a year to fill the anticipated 600 openings in community pathology practice.

We do not know of the exact number of pathologists that is needed in the United States; we know of no data that will give one this number. We do believe that the decline in physicians entering pathology practice, combined with the graying of practicing pathologists, produces a situation that will likely produce a shortage of pathologists by the year 2000. Literature supporting our concern is attached (Attachment B).

As consideration of reforms in payment for Graduate Medical Education proceed, we strongly encourage the Congress not to adopt a restructuring of the federal payment for Graduate Medical Education that either gives incentives for pathology residencies to be reduced in number or quality, or creates additional disincentives for medical students to enter pathology practice. These disincentives are already in place and working, too well in our estimation.

Conclusion

The College of American Pathologists understands that physicians will be expected to contribute to the effort to reduce federal health care spending and the budget deficit. Pathologists want to be involved in how that contribution is configured and to ensure that pathology does not bear a disproportionate share of the load. Pathology and laboratory medicine has already undergone a series of reform initiatives over the last decade. We should not be singled out for additional reductions and changes beyond what all physicians in general will bear.

In summary, bundling of pathology services into a payment made to another entity is a totally unsound idea that has been rejected by the Congress previously and should be so again. Reductions in practice expense relative value components without adequate data in that regard are not an intermediate step to a resource-based system but are just a budget reduction mechanism. We urge you not to confuse the two with adoption of this intermediate proposal.

We are willing to work with the Congress to address pathologists' and laboratory medicine's contribution to health care spending reductions, both with regard to the RVS fee schedule and to the clinical laboratory fee schedule.

Thank you for the opportunity to present this statement to the Subcommittee on Health and the Environment.

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ATTACHMENT A

Major Restrictions In Payment for Medicare Clinical Laboratory Services:

July 1984: Clinical Laboratory Fee Schedule Established

- Carrier fee schedules were implemented for clinical laboratory services performed in hospitals for outpatients, in physicians' offices, and in independent laboratories. Payments were set at 60% of prevailing charges for independent laboratories and physicians' offices; and at 62% for hospital outpatient services.
- Mandatory assignment was instituted for independent laboratories and hospitals.

July 1, 1986: Fee Schedule Caps Established

- Carrier fee schedule amounts were capped at 115% of the median of all fee schedule amounts.

January 1, 1987: Payments Reduced; Assignment Expanded

- Hospital fee schedule amounts were reduced from 62% to 60% of the prevailing charge, except for hospitals with 24 hour, 7 day a week emergency room services.
- Physicians' office laboratories were required to accept assignment.

January 1, 1988: Update in Fee Schedule Eliminated

- Laboratory fee schedule inflation updates were eliminated.

April 1, 1988: Payments Reduced

- The 2% differential was eliminated for all hospital laboratories except those operating qualified emergency rooms in sole community hospitals.
- Fee schedules for high volume tests were reduced by 8.3%.
- The fee schedule caps were reduced from 115% to 100% of the median of all fee schedules.

January 1, 1990: Payments Reduced

- The fee schedule caps were reduced from 100% to 93% of the median of all fee schedules.

January 1, 1991: Update Limited; Payments Reduced

- The fee schedule caps were reduced from 93% to 88% of the median of all fee schedules.
- Laboratory fee schedule inflation updates were limited to 2% (4.3% was scheduled).

January 1992 and 1993: Updates Limited

- Laboratory fee schedule inflation updates are limited to 2% regardless of inflation.

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April 1991

ATTACHMENT B

Special Article

National Pathology Manpower Survey of 1988

Manpower Needs in Community Hospitals and Private Laboratory Practice

Ellis S. Benson, MD; Roger D. Smith, MD; Robert E. Anderson, MD; Daniel Tholen, MS

• The survey of manpower in community hospital and private laboratory practice of pathology of 1988 presented herein verifies the conclusions of the 1986 survey that a growing deficit of manpower in this sphere of practice is highly likely in the next few years. It appears that the deficit will be even larger than that predicted by the 1986 survey. Steps are urgently needed to increase the flow of graduating medical students, especially those of top quality, into our specialty.

(*Arch Pathol Lab Med.* 1990;114:566-569)

This is the sixth of a series of articles concerning pathology manpower needs in the United States and the second such study using the National Pathology Manpower Database (NPMD).[1-5] The latter consists of a subset of practicing pathologists defined so as to be representative of the discipline in terms of type of practice, age, gender, and geographic location. The first survey using the NPMD was performed in 1987 and showed an impending serious shortage of pathologists engaged in practice in community hospitals and/or private laboratories, a group henceforth referred to as *community pathologists*. This article which is concerned with community pathologists, also deals with data from the second yearly survey of a longitudinal study of this practice group initiated to determine the kinetics of manpower and especially losses to the specialty due to death, retirement, and major career changes. Further, the NPMD is being exploited to determine the characteristics of community practice and detect changes that have implications for future manpower needs in pathology.[5]

MATERIALS AND METHODS

The development and structure of the NPMD is described in detail elsewhere.[5] In brief, a representative subset of 4669 pathologists was defined. Of this sample, 2469 indicated a willingness to participate in repeated surveys. In comparison with the American Medical Association (AMA) database, the latter group was shown to be representative of the universe of practicing pathologists in terms of age, practice setting, and geographic location. Only in terms of gender was there a difference between the NPMD and the AMA database with a deficit of women in the former (12.4%) in comparison with the latter (19.6%).

THE NPMD BY DEFINITION AGES

To keep this subset representative of the universe of pathologists, new persons are added to replace previous participants who retired, died, changed to a new career other than pathology, or declined to continue to participate in these surveys. As a result, our survey includes 580 community pathologists who participated in the 1987 study and 206 persons who did not, who were added on the basis of demographic representation.

The survey form consisted of a two-page questionnaire in two parts, both of which required the respondents to check choices and fill in specific numerical information. The first part was to be completed by the individual pathologist who received the form. The requested information concerned the pathologist's current professional activities and career plans. The second part asked for information concerning the group in which the pathologist practiced to include group size, professional responsibilities, and manpower changes that had occurred over the prior 3 years and those anticipated for the subsequent 1 year and 2 to 5 years. The 1988 survey form was similar to the one employed in 1987 except that an opinion poll was omitted because it provided little useful information.

The questionnaire was sent with a cover letter to 786 pathologists in January 1988. Subsequently, 70 of the 786 pathologists were excluded on the basis of a determination that they had entered federal service or academic pathology or declined to participate, resulting in 716 as the surveyed group. After a second mailing in February 1988 and one in March 1988, 562 completed responses were received by April 15, 1988, for a response rate of 78.5%. The data were analyzed using a computer (IBM model 7341) at the College of American Pathologists' Computer Center in Traverse City, Mich. An additional 20 respondents who returned their questionnaires after individual data analysis were included for analysis of practice group data resulting in a response rate of 81% for surveyed practice groups.

RESULTS

Table 1 compares this study sample with the AMA database in terms of general demographics. Overall, the two groups are highly comparable except for a deficit of women and a modest

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underrepresentation of young (<35 years) and old (>64 years) pathologists in the study sample. The deficit of women is almost entirely confined to the less than 35-year-old age group (data not shown) and probably reflects: (1) an unknown proportion of residents and fellows in the AMA database; and (2) a recent trend toward an increased proportion of female residents in training. In this context, it is important to note that the AMA figures used to construct the NPMD, although published in 1987, are from data gathered in 1985.

The geographic and age distribution of the 562 pathologists responding to the survey are shown in Table 2. The greatest number of respondents practice in the Southern region, with the smallest number in the Western region. In general, the age distribution is similar for the four regions except that the majority of those over 64 years of age are practicing in the Southern region. Approximately one fourth of respondents are over 55 years of age.

Table 1.—Comparison of Study Sample With the National Pathology Manpower Database (NPMD) and American Medical Association (AMA) Database*

Category	Study Sample	NPMD	AMA Database'
Age, y			
<35	15.5	7.4	22.2
35-44	30.6	29.4	28.2
45-54	28.7	28.7	25.3
55-64	21.5	23.2	18.1
>64	3.0	11.3	6.0
Gender			
Male	86.4	87.5	80.6
Female	13.6	12.5	19.4
Location by region			
Western	16.9	19.3	19.7
North Central	26.2	24.6	25.0
Southern	31.8	32.6	31.1
Northeast	24.4	23.6	24.0

*Results are given as percent of total pathologists in indicated category.

Each individual respondent was asked to indicate anticipated career changes in the subsequent year and/or the following 2 to 5 years. The choices provided in the questionnaire were as follows: (1) no change anticipated; (2) change to a different position in pathology; (3) change to a position in a different specialty; (4) retire; and (5) other major changes that the respondent was asked to describe. Of 562 individuals who responded to this question, 461 indicated that no change was anticipated. Twenty-nine indicated that they expected to retire or leave pathology for another specialty. An additional 3.5 full-time equivalents anticipated leaving pathology or going from full-time to part-time within the next year after subtracting those going from part-time to full-time (Table 3). An additional 100 individuals indicated that they anticipated leaving pathology during the subsequent 4 years. Actuarial data, adjusted for the age and sex of the respondents and based on 1987 mortality tables from the US Census Bureau, indicate an anticipated 3.85 vacancies in 1 year and an additional 17.4 openings in the next 2 to 5 years due to death. When extrapolated to the total population of pathologists practicing in community hospitals (11 423), 739 vacancies from all causes are projected for 1 year and an additional 2397 positions over the subsequent 2 to 5 years, for a total of approximately 3136 vacancies in 5 years (1988 through 1993).

The 582 participants included in this survey for analysis of group data represent separate practice groups of varying size. Whereas over 50% of the reporting pathologists practiced in groups larger than six individuals, 123 (21%) were in solo practice. Excluding those in solo practice, the mean group size was 3.4. To have representative data about pathology groups, the survey forms were sent only to individuals in different groups. Questions similar to the above were asked concerning anticipated personnel changes in the entire practice group in the subsequent 12 months and during the next 2 to 5 years. In addition, the respondent was asked to indicate the presence of currently vacant positions and new antici-

Table 2.—Geographic Distribution of Respondents by Age*

Age, y'	Western	North Central	Southern	Northeast	% of Total Respondents
<35					
% in region	10.2	17.1	16.8	16.2	15.5
% in age group	11.1	28.9	34.4	25.6	
35-44					
% in region	30.8	29.6	29.8	28.9	30.7
% in age group	20.8	25.3	30.9	23.0	
45-54					
% in region	29.6	28.9	26.5	31.7	28.7
% in age group	17.4	36.4	29.3	26.9	
55-64					
% in region	22.4	21.0	21.0	22.5	21.5
% in age group	17.6	25.6	31.2	25.6	
>64					
% in region	0.0	3.3	6.0	0.7	3.0
% in age group	0.0	29.4	64.7	5.9	
% of total respondents	16.8	26.2	31.8	24.9	99.4

*Western indicates Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, and Wyoming; North Central: Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Nebraska, North Dakota, Ohio, South Dakota, and Wisconsin; Southern: Alabama, Arkansas, Delaware, District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, and Virginia; Northeast: Connecticut, Maine, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, and Vermont.

Table 3.—Anticipated Changes of 562 Responding Pathologists

Change	1 Year	Subsequent 4 Years	Total at 5 Years
Retire	17 0	79 0	96 0
Change specialties	12 0	10.0	22 0
Other*	3 5	11.5	15 0
Death†	3 85	17 42	21 27
Total	**36.35**	**117.92**	**154.27**
Extrapolated to 11 423 community pathologists	739	2397	3136

*Full-time to part-time, law, forensic pathology, hospital administration, and industry.

†Age/gender adjusted actuarial data from statistical abstracts, United States Census Bureau, 1987, page 71.

Table 4.—Anticipated Changes of 459 Pathology Groups*

Change	1 Year	Subsequent 4 Years	Total at 5 Years
Retire	46	235	281
Resignation/termination	36	50	86
Full-time to part-time minus part-time to full-time	22	21	43
Vacant positions	41	. . .	41
Subtotal	145	306	451
Extrapolated to 11 423 community pathologists†	634	1338	1972
Projected new positions	115	165	280
Extrapolated to 11 423 community pathologists	503	722	1225
Total†	1137	2060	3197

*Encompasses 2612 community pathologists in groups of two or more.

†Does *not* include deaths.

Table 5.—Loss of Pathologists From 459 Practice Groups During the Past 3 Years*

Reason	No. Unavailable	Extrapolated to Universe†
Resignation	147	643
Retirement	99	433
Termination	37	162
Deaths	25	109
Total	308	1347

*Results based on 3 years before survey and encompass 2612 community pathologists

†Universe constitutes 11 423 community pathologists.

pated positions during the next 5 years. Using these data, without the addition of unanticipated attrition because of death, it was determined that, including the current vacancies, there would be 634 positions open within 1 year and an additional 1338 positions vacated over the next 2 to 5 years (Table 4). If new positions for the 459 practice groups of two or more pathologists are included, based on this group data there is an anticipated national need for 3197 new pathologists over the next 5 years, in addition to undetermined losses due to death.

To get some idea of the kinetics of change in pathology practice groups, we asked how many individuals had left the surveyed groups over the past 3 years due to resignation, retirement, termination, or death. Data from the 459 groups extrapolated to the entire population of pathologists indicate a turnover of approximately 1346 individuals or approximately 450 per year (Table 5). This figure does not include openings because of vacant positions or new positions and compares well with the 454 anticipated open positions in groups based on retirement (46), resignation (36), or other changes (22) without currently vacant positions and extrapolated for 11 423 pathologists as listed in Table 4 (104 × 4.3732 = 454).

COMMENT

The primary aim of the longitudinal survey of pathologists in community practice is to determine the number of individuals lost to this practice setting over time to project the need for new pathologists. The NPMD was constructed to make such a survey possible without tracking all 11 423 individuals in community practice. The surveyed group is, with the exception of gender, demographically representative of the 11 423 pathologists when compared with the AMA database, the most comprehensive listing of US pathologists based on practice characteristics and geographic distribution. Ideally, the longitudinal survey should document the actual percentage of retirements, deaths, and other changes in the previously surveyed group, so that the predictions made following the 1987 survey could be validated. Although we were unable to trace all the nonresponders who were in the first survey group, follow-up of most of them indicates that the 1987 projections are surprisingly accurate. Surprising because, although individual pathologists apparently change even in their 1-year career plans rather acutely, these last-minute changes tend to balance out in terms of manpower projections. For example, of the 9 pathologists who indicated in 1987 that they planned to retire in 1 year, only 3 actually did so. However, they were joined by 4 others who retired sooner than anticipated. Of the 6 remaining individuals who had indicated retirement within 1 year, 3 were working part-time, 2 were working full-time, and 1 was unavailable for follow-up. Of the 16 pathologists who indicated in the 1987 survey that they planned career or specialty changes within the next year taking them out of community practice, only 3 had actually followed this course. Eight continued in full-time practice; 5 went from full-time to part-time; 1 went from part-time to full-time; and 2 were unavailable for follow-up. However, 2 others who had anticipated major changes at 5 years had already made this change by 1988. A significant percentage of the 70 individual respondents to the first survey who failed to respond in the second one could not be readily traced and are presumed to be retired from pathology or dead. This suggests that the projections made in 1987 anticipating approximately 30 of 629 respondents leaving practice over 1 year was probably on the low side.

With the exception of carefully following a large cohort of practicing pathologists and exhaustively tracking down nonresponders to confirm that they have left the practice or died, the next best determination of attrition is based on the responses of individual pathologists indicating anticipated change over the next year and/or 2 to 5 years added to the actuarial death rate based on the age and gender of the respondents. Based on 562 individual responses in the 1988 survey extrapolated to the total number of pathologists in this practice setting, there will be an approximate loss of 3000 pathologists from community hospital and private laboratory practice over the next 5 years or, as a conservative estimate, 600 per year. Another determination of turnover is based on the projected losses from practice groups. Using this method, it is impossible to estimate actuarial loss, since death rates depend on age and gender, information that is not available for all members of the group. Without deaths, but including current vacancies and projected new positions, it is anticipated that there will be over 3000 positions in the next 5 years (Table 4); again, approximately 600 per year. Using somewhat harder data representing reported losses from the practice groups over the past 3 years, there was dropout of 450 pathologists per year due to resignations, retirement, termination, and death (Table 5). Although some of these may account for the current vacancies, it is likely that new positions and the filling of preexisting vacancies and replacement of losses would require close to 600 new pathologists entering community practice each year. This estimate is significantly higher than the 500 per year over 5 years predicted after the 1987 survey and reflects a much larger number of anticipated retirements (17 of 562 in 1988 vs 9 of 629 respondents in 1987).

What are the causes of the growing deficit? Based on the two surveys carried out in 1987 and 1988, and comparison with residency recruiting and training data, we judge that the basic cause is inadequate replacement of those leaving community practice. Retirements from the specialty are exceeding the rate experienced in recent years. As we noted in our article of the 1987 survey,[5] there will be a significant increase in the number of pathologists who will be retiring in the decade that began in 1988. Pathology experienced a major influx of specialists in the two decades following World War II. The numbers of physicians in the specialty expanded from 1500 in 1944 to 6000 in 1960. We anticipate that one third of the pathologists who entered practice between 1940 and 1965 will have reached retirement age by 1994. This number of individuals, added to attrition because of career changes and unexpected deaths makes up the 3000 pathologists in community practice who will need to be replaced over the next 5 years.

Over the past 5 years, there have been approximately 500 new pathologists that have completed training each year in the United States.[8] In a 1989 survey of residency program directors, it was indicated that only 297 newly trained pathologists entered community practice in 1989 with 353 projected to enter practice in 1990.[9] Currently, there is a total of 2719 individuals in all phases of pathology training from the first to the fifth and fellowship years, with 681 at the first-year level and 454 at the fourth-year level (R. D. Smith, MD, R. P. Vance, MD, R. W. Prichard, MD, unpublished data, 1989). Approximately 75% of newly training pathologists are predicted to enter community practice, with the remaining 25% pursuing careers in academic pathology, the military service, forensic and government jurisdictions, and industry. This leaves much less than 400 new pathologists a year to fill the anticipated 600 openings in community pathology practice.

The findings that we present call for urgent steps to increase the inflow of physicians into the specialty of pathology. Medical students must be made fully aware of the opportunities in this critical practice sphere, so that the existing residency programs that are now approximately 85% filled can increase the number of well-trained new pathologists available for practice. There may be a need to increase the number of residency training positions in pathology to meet the demand. When comparing the 1987 and 1988 survey figures with those related to the number of residents completing their pathology training, it is apparent that there are already serious shortages impacting on all areas of pathology practice. The Joint Task Force on Pathology Manpower is currently carrying out a survey of academic pathology. It is likely to reveal numerous vacant positions and a significant and recent movement of pathologists from academic departments to community practice.

The collected manpower data, based on anticipated attrition and current vacancies, can be considered a "demand assessment model" of manpower needs. However, the Joint Task Force on Pathology Manpower is also accumulating workload data and tracking the growth of overall workload as a function of time. Some workload data from the 1987 survey have been recently included in an article describing the characteristics of pathology practice.[6] As additional workload data accumulate during the longitudinal survey, it should be possible to develop a "needs model" to project the need for future manpower based on the volume of activities in pathology practice.

Contributing to the manuscript preparation was the Joint Task Force on Pathology Manpower (ASCP/CAP/APC), which includes Roger D. Smith, MD; James R. Edwards, MD; William H. Hartmann, MD; Herbert M. Sommers, MD; Ellis S. Benson, MD; J. Scott Abercrombie, Jr, MD; Donald A. Dyneck, MD; William A. [illegible], MD; and Robert E. Anderson, MD.

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Editorial

Key Discriminators in the Manpower Equation

The severity of the current manpower situation in pathology has been carefully documented both with respect to community practice and to academia.[1-4] The sudden emergence of the present deficit, a shortfall that is expected to worsen significantly over at least the next 12 to 15 years, caught most pathologists by surprise. Their initial response was one of disbelief. Once convinced of the severity of the situation and of the implications for the future of the discipline, however, these same individuals next ask, "Well, how badly are we doing?" This seemingly straightforward question is, in fact, much more difficult to address than might be anticipated.

In the current issue of the *Journal*, Vance et al[5] provide a wealth of information concerning trainees in pathology. These individuals, and their successors, constitute a major piece of the manpower puzzle; with rare exceptions, pathology training programs in the United States provide all academic, community hospital, and government-employed pathologists for this country. As a consequence, the prognosis for pathology manpower is largely dependent on the kinetics of the training situation. But which of these numbers are most important and do they provide any reason for optimism? More importantly, can any single parameter serve as a benchmark for success?

Historically, persons interested in pathology manpower have been obsessed with "the match." Every spring the National Resident Matching Program (NRMP) publishes, on a program-by-program basis, the number of senior medical students who selected an institution as well as the number of positions offered. In the past, and especially during the period from 1970 to 1988, match results were a good indicator of the manpower situation. However, a number of problems have emerged to weaken the match's value as an indicator. With the implementation of the fifth year, 10% to 20% of medical students planning a career in pathology have elected to match in another discipline (internal medicine, pediatrics, etc) for their first postgraduate year. In addition, pathology has become the alternative career choice of an increasingly large number of persons who started out in another specialty and then, for a variety of reasons, modified their plans. Program directors seem to accommodate these transplants by shifting slots out of the match. Finally, pathology also suffers significant attrition during the training process. This phenomenon, which may involve 30% to 40% of all entrants to the training process, is not reflected in match results. Thus, the total number of positions offered and filled via the NRMP only indirectly reflects the trainee manpower situation and is a generally poor indicator of the supply side of the manpower equation.

The total number of training programs and resident positions and the proportion of positions filled have similar drawbacks as prognostic barometers. Each fails to reflect the attrition problem. Some account must also be taken of training programs that chronically underfill, even though recent efforts by the Pathology Residency Review Committee have markedly reduced the number of such institutions. The number of trainees in each year of training is an important piece of data, but only in association with the size of the entering class, so as to permit the calculation of attrition.

Historically, pathology training program directors have tended to fill open slots with graduates of non-US medical schools rather than leave such positions vacant and susceptible to reassignment to another specialty. As a result, roughly 25% of the practitioners of pathology today are graduates of foreign medical schools (FMGs). The proportion of FMG trainees is therefore an indicator of our success, or lack of same, in attracting US graduates. However, at best, this indicator represents an indirect measure of success. It also undoubtedly offends many excellent pathologists who either (1) trained abroad or (2) competed successfully with American graduates for a US training slot.

Clearly, the most straightforward approach to the issue is to examine the relationship between (1) the number of practicing pathologists lost to the discipline (due to death, retirement, etc) versus (2) the number of graduating house staff entering practice. With steady-state kinetics, this number would be 1.0. Results from the most recent manpower surveys indicate that in community practice, for example, this figure is 0.41.[4,5] Unfortunately, virtually no historical data are available with respect to gains versus losses. In addition, this approach assumes that all current positions in pathology are necessary. This "supply" model is in contrast to the "demand" approach whereby a full-time equivalent pathologist is defined in terms of work units (number of procedures, tests, etc, accomplished per annum). As might be expected, the "demand" approach is much easier to apply to morphologic responsibilities in pathology than to clinical pathology and laboratory administration. Despite the inherent problems, however, the National Pathology Manpower Task Force hopes to develop "demand" data for all facets of pathology practice in the community practice setting during the next 3 to 5 years. In the interim, an alternative strategy to the manpower conundrum would be highly desirable.

Perhaps the best interim strategy to assess success in the manpower realm is to compare two ratios: the proportion of physicians who are pathologists (currently 2.74%) versus the proportion of all trainees who are in pathology training programs (2.78%). This comparison indicates that we are apparently holding our own. However, comparable data for the past several decades (Fig 1) suggests that this is not the case. The trainee/practitioner index (TPI) shows a progressive erosion during the period from 1965 to 1988. The basis for this apparent inconsistency is the fact that the TPI fails to take into account trainee attrition. Therefore, the better comparison would involve the ratio of pathology graduates (newly minted pathologists) to graduates of all training programs. Unfortunately, only the number of pathology graduates is currently available. However, assuming an attrition rate of 30% to 40%,[5] we can modify the TPI to take this into account and generate the following index of success:

$$\frac{N - (N \times \% A)}{T}$$

where N is the total number of pathology house staff, A is attrition during the entire training process, and T is the total number of house staff. With most recent data, the present situation is as follows:

$$\frac{2,733 - (2,733 \times 0.35)}{85,330} = 2.08$$

This figure is then compared with the proportion of all physicians who are pathologists (2.74).

This is, unfortunately, just a snapshot of a highly dynamic situation. Enough photographs over a sufficient time frame permit a reasonable assessment of the overall situation. However, unless each picture is labeled with the time and date, it remains difficult to get a sense of the kinetics of the situation, especially the ever-changing relationships among recruitment to the field as a beginning resident, completion of training and entry into the job market, and demand for services on the part of community hospitals, academia, and government.

This brings us to our last point. Attrition is the most serious, potentially remediable problem facing us today in the manpower realm. Although training in pathology is undoubtedly of value, regardless of one's ultimate specialty area, providing 2 or more years of such experience to individuals destined to leave pathology seems like a poor use of a finite resource (eg, training slots). We have been told that some program directors in radiology encourage prospective residents to spend a year in pathology prior to formal entry into a radiology residency. This approach may well be highly beneficial for both disciplines. However, by all indications, the number of involved trainees is vanishingly small. In this context, the largest loss of pathology trainees is after year 1, but a significant proportion (39%) occurs subsequently. The loss of persons who have spent 2, 3, and even 4 years in pathology training is a tragedy. It implies that significant numbers of persons either entered training in pathology not understanding what characterizes the discipline or decided during the training process that their career aspirations could not be accommodated by the specialty. Either way it is unfortunate. If all currently filled training positions in pathology were occupied by individuals destined to complete training and enter the job market in pathology, we would be holding our own; as it is, with an attrition rate of 30% to 40%, we are falling further and further behind.

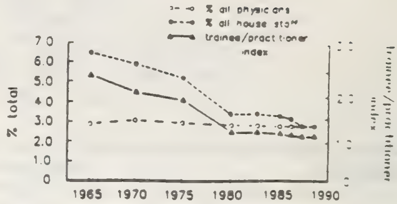

FIGURE 1. Proportions of total physicians and house staff who are pathologists and trainee/practitioner index as a function of time in the period from 1965 to 1988.

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Current Topics

The Accelerated Graying of American Pathology

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The results of the 1988 survey of the National Pathology Manpower Database (NPMD) have been analyzed and join an increasing body of evidence in support of a current deficit of pathologists engaged in community practice in the United States, a shortfall that promises to worsen for the foreseeable future.[1-3] A more recent assessment of military pathologists and others employed by the federal government also reveals a growing shortage, one unlikely to be negated by current and projected residents in the federal pipeline. We are currently in the process of reanalyzing the third component of the manpower equation, academic pathology; there is no reason, however, to think that the situation has improved since the last such survey in 1984 which demonstrated a marked shortage.[4] In fact, discussions with pathology chairmen and preliminary analysis of the academic manpower data suggest that the situation has worsened significantly in the interim.

We recognize that it is difficult to understand the basis for the situation described above. It seems like just a short time ago that graduates of pathology training programs in the United States were experiencing difficulty in locating positions, especially in the community practice setting. A series of federal initiatives, concerned primarily with reimbursement, further confounded the manpower equation and prompted some to discourage medical students interested in a career in pathology. What then has changed? And what is the etiology of the current and impending shortage of pathologists?

In this presentation we will review the manpower kinetics in American pathology and show that the current shortage of both academic and community hospital-based pathologists was predictable on the basis of the demographics of pathologists and the resultant disequilibrium between the number of persons entering and leaving the discipline. Furthermore, although this shortage is of moderate magnitude at present, it can be expected to worsen dramatically during the next 7 to 10 years. And finally, absent a marked increase in American medical students electing a career in pathology, this shortage can be expected to continue for the foreseeable future.

NUMBERS OF PATHOLOGISTS

Prior to World War II, there were relatively few pathologists in the United States. As shown in Fig 1, the American Medical Association listed fewer than 1,000 pathologists in 1940,[5] the first year that such data are available. During the subsequent 45 years, however, the discipline grew by almost 16-fold to encompass 15,456 individuals. By contrast, during the same time period, the total physician pool grew by roughly threefold from 175,163 to 552,716 (Fig 2).[5] The result has been an increased proportion of physicians who are pathologists, a figure which reached a peak of 3.1% in 1970 (Fig 3).

DEATHS AND RETIREMENTS

Prior to World War II, a rough equilibrium appears to have existed with respect to manpower kinetics in pathology: the number of persons entering the discipline approximated those leaving due to death, retirement, etc. After the War, and especially from 1955 to 1970, the field of pathology expanded dramatically and entrants markedly exceeded those leaving. Today, however, these post-War entrants are being lost to the discipline by retirement and death.

It stands to reason that the exponential character of the growth curve of pathologists experienced from 1955 to 1970 must subsequently be mirrored by a similar death/retirement curve. The interval between these two curves will be the average professional lifespan of the involved individuals. In pathology, this figure is currently 25 to 30 years as based on the following observations: average age at completion of residency training, 34 years[5]; average age of retirement, 62 to 65 years (see below); and a current average of 6.86 deaths/1,000 pathologists per year.[2]

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Key words: graying of pathology.

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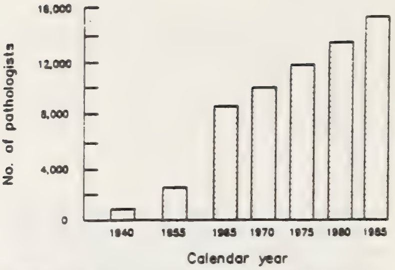

FIGURE 1. Number of pathologists in the United States as a function of time, 1940 to 1985.

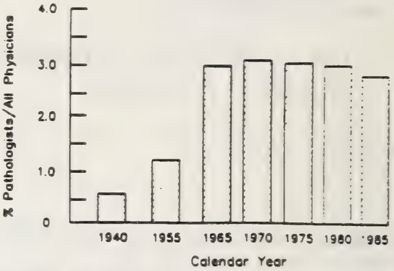

FIGURE 3. Pathologists as a percentage of all physicians in the United States, 1940 to 1985.

PATHOLOGY HOUSE STAFF

Figure 4 shows the total number of pathology house staff as a function of calendar year.[5] Assuming an even distribution of residents over the 4-year pathology training period extant until recently, we have to date estimated roughly 600 resident-graduates per year. However, this figure fails to take into account the implementation of the fifth year or the significant attrition that occurs among pathology residents during the training process. The impact of these two phenomena is as follows:

1. Attrition—Recent data suggest that attrition constitutes a major problem in pathology and that roughly 40% of persons that begin training in pathology fail to finish.[6]

2. Fifth year—In most institutions, implementation of the fifth year was not accompanied by an increased number of resident slots. Rather, the preexisting quota was spread over 5 rather than 4 years. In theory, this change would be expected to result in the loss of one class of graduates and a 20% reduction in class size. However, in actual fact, the impact is less than anticipated.

The overall effect of these two phenomena is to reduce significantly the number of resident-graduates per year. Recognizing that the effects may be overlapping (eg, individuals with 1 or several years of clinical training may start but fail to complete a residency in pathology and thus become a subset of the attrition issue), it seems likely that we can only expect 330 to 350 additions to the pathology job market per year. A significant proportion of trainees historically have taken 1 or several years of clinical training prior to beginning a residency in pathology[7]; this clinical year(s) meets the fifth year requirement and thus entails no additional time in a pathology residency for the involved individuals. Assuming that 25% of entering house staff have had 1 or more years of clinical training,[8] and that attrition remains at the current level, we can expect to generate approximately 350

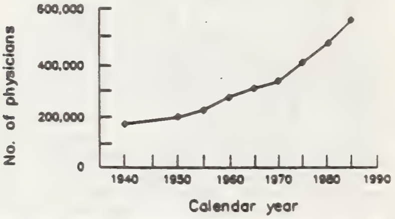

FIGURE 2. Number of physicians in the United States as a function of time, 1940 to 1985.

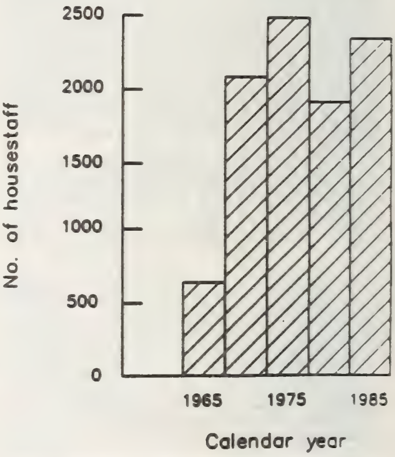

FIGURE 4. Number of pathology house staff as a function of time in the United States, 1965 to 1985.

TABLE 1. Anticipated Vacancies Among Community Pathologists: 1986 National Pathology Manpower Survey*

Change	1 Year	Subsequent 4 Years	Total at 5 Years
Retire	9.00	82.00	91.00
Change specialties	5.00	7.00	12.00
Other major career changes†	11.00	19.00	30.00
Deaths‡	2.55	21.98	24.53
Total	27.55	129.98	157.53
Extrapolated to 11,476 community pathologists	502.60	2,371.26	2,873.86

* Results based upon responses from 629 community pathologists.[1]

† Hospital administration, change to nonmedical career.

‡ Based on 1984 actuarial tables for teachers adjusted for age and gender.

resident-graduates per year for the foreseeable future.

KINETICS OF PATHOLOGY MANPOWER

Tables 1 and 2 show anticipated vacancies in the community practice of pathology. Historically, 70% of the graduates of residency training programs (roughly 250 persons per year) have gone into community practice with the remainder electing careers in academic pathology and government service. Keeping these figures in mind, the magnitude of the shortfall of pathologists in the community setting is evident in Table 3. The numbers of current and anticipated vacancies greatly exceed the supply of pathology house staff completing their training and entering the job market. Comparable data derived from the 1984 survey of academic pathologists and departmental chairmen[4] are also included in Table 3. In sum, the discipline is losing an average 1.87 pathologists per day; as of July 1990, these positions are being replenished on average by 0.96 newly minted graduates of our training programs per day. In other words, the manpower equation is in marked disequilibrium; gains only represent slightly over half of losses. And as we enter the steep portion of the retirement curve, the situation can be expected to worsen.

TABLE 2. Anticipated Vacancies Among Community Pathologists: 1988 National Pathology Manpower Survey*

Change	1 Year	Subsequent 4 Years	Total at 5 Years
Retire	17.0	79.0	96.0
Change specialties	12.0	10.0	22.0
Other†	3.5	11.5	15.0
Deaths‡	3.854	17.421	21.275
Total	36.354	117.921	154.275
Extrapolated to 11,423 community pathologists	738.91	2,396.82	3,135.73

* Results based on responses from 562 community pathologists.[2]

† Full to part-time, law practice, forensic pathology, hospital administration, industry.

‡ Age/gender-adjusted actuarial data.[9]

TABLE 3. Results of Recent Manpower Surveys and Implications for the Future

Segment Surveyed	Year of Survey	No. of Vacancies at Time of Survey	Anticipated Losses*	
			1 Year	5 Years
Academic	1984	272	137†	649†
Academic	1990	367	145	Unknown
Community hospital	1986	170	503	2,874
Community hospital	1988	179	739	3,136
Government service‡	1989	14	25	Unknown

* Due to retirement, death, change in specialty, relocate to industry, etc; losses due to death in academic sector are based on the assumption that academic and community hospital pathologists exhibit comparable age and gender distributions.

† Does not include anticipated losses in community practice

‡ Includes only uniformed services; data for Veterans Administration not available.

THE FUTURE

As indicated above, barring unforeseen events, the current disequilibrium in pathology manpower will become increasingly severe until at least 2007 or the year when the average person entering the discipline at the end of the exponential growth phase (1975) can be expected to retire. There are a number of variables that confound manpower data in pathology. Unfortunately, each of these would tend to suggest that the situation in the future may be even worse than currently anticipated. These variables relate to age of retirement and numbers of foreign graduates entering the discipline.

Currently there is a tendency for physicians in general to retire at a younger age than in the past[10] (and unpublished data). Pathologists not only share this tendency but may actually be trendsetters. In 1986, the average estimated retirement age of community pathologists in the NPMD was 62[1] and in 1988 it was 65.[2] In 1988, 24.5% of community pathologists in the NPMD were 55 years of age or older and the mean age was 52 years.[2] In other words, almost half of the discipline can be expected to retire in the next 10 to 15 years (assuming that they don't die first). This tendency toward early retirement is reflected in the relative deficit of pathologists over 65 years of age in comparison with other physicians as shown in Table 4. This table also reveals a highly uneven representation of pathologists by the indicated age groups, a phenomenon which relates in large measure to recent recruitment problems[11] that have resulted in a paucity of pathologists in the younger age groups.

In the past, shortfalls of American pathologists have been partially muted by foreign medical school graduates (FMGs) of both American and foreign heritage. As a consequence, approximately 40% of community pathologists in the NPMD are graduates of other than US medical schools. All indications at

TABLE 4. Numbers of Physicians and Pathologists as a Function of Age*

Age (y)	No. of Physicians	No. of Pathologists	% Pathologists
Below 35	142.328	3.269	2 3
35 to 44	162.461	4.699	2 9
45 to 54	102.665	3.930	3.8
55 to 64	80.321	2.894	3 6
Over 65	81.385	999	1 2
Total	569.160	15.791	2.8

* Data from Smith et al.[4]

present, however, suggest that this source of pathologists is drying up. Firstly, the number of American citizens studying abroad, including those enrolled in Caribbean and other offshore medical schools, has decreased markedly over the past several years. Secondly, Congress appears intent upon curtailing federal reimbursement of hospitals for FMG house staff. And finally, there is an increasing ambivalence among pathology chairmen, in whose departments the vast majority of residency education takes place, concerning the wisdom of accepting large numbers of residents whose education transpired at other than American schools.[11] Finally, the recent decrement in medical school graduates interested in primary care has created a vacuum that program directors in pediatrics, family practice, and internal medicine have attempted to address via FMGs.

NEEDS VERSUS DEMANDS MODEL OF PATHOLOGY MANPOWER

The above projections are based upon a "demand" model, eg, numbers of pathologists required for various types of practice as projected on the basis of current market forces. One could argue that this approach overstates the situation, that there are currently too many pathologists and that manpower projections are better based on a "needs" model, eg, how many pathologists are required to meet current workload in terms of numbers of surgicals, cytologies, clinical laboratory determinations, etc.

Relevant observations in this regard are as follows: (1) the average number of hours devoted to professional activities by community pathologists is significant (over 50 hours per week) and is increasing, especially when individuals working on a part-time basis are excluded—as a result, there is a limit to which services can be expanded without an increase in personnel; (2) market forces currently dictate in large measure numbers and geographic distribution of specialists other than pathologists and, absent some type of national health service involving all physicians, there is no reason to anticipate that a "needs" model will be applied solely to pathology; (3) at present, market forces unequivocally dominate manpower kinetics in pathology: as a consequence of the shortage of pathologists, there has been an acute shift in the past 1 to 2 years of academic and government-employed pathologists to the community practice setting, especially in the midwest; (4) the Graduate Medical Education National Advisory Committee Report of 1975, using a modified needs model, projected a requirement for 16,000 pathologists in 1990.[12] The current (1989) number is roughly 15,900 including persons in special training status (fellowship, full-time research, etc). Thus, on the basis of the only comparison available, the "needs" model projected a requirement remarkably similar to that which eventuated under "demand" conditions.

EPICRISIS

In summary, information from several different sources indicates that we have entered a phase characterized by a significant shortage of pathologists in the United States, specifically those based in community hospitals and academic medical centers or engaged in government service. As shown in Fig 5, current losses exceed gains by a ratio of almost 2:1. In order to meet the current shortfall of pathologists (Table 3) with American graduates, roughly 6% of medical students would need to seek a career in pathology; in recent years, this figure has been in the 2.1% to 3.1% range, or less than half of what is needed.[7] Furthermore, the current shortage will become increasingly severe for the foreseeable future and, in the absence of unforeseen events, will not

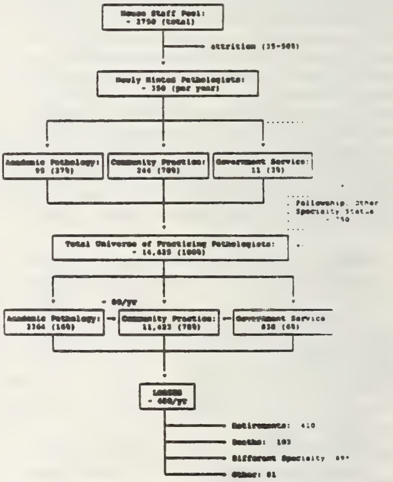

FIGURE 5. Summary of manpower kinetics in the field of pathology in America, 1989. *Based on 5-year estimate from 1988 survey of community pathologists and assumes no career changes among academic and government service pathologists.

even stabilize (albeit at a distinct shortage level) under the most optimistic circumstances until the next century.

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THE COUNCIL OF NURSING HOME SUPPLIERS

Mr. Chairman and members of the Subcommittee, my name is Neal Thrift. I am Vice President of Care Supply, Inc., a nursing home supply company, and I am also Chairman of the Council of Nursing Home Suppliers. I am pleased to have the opportunity to present written testimony, on behalf of the Council of Nursing Home Suppliers, regarding the Administration's FY 1994 Medicare budget.

The Council of Nursing Home Suppliers members provide services to more than 100,000 nursing home residents in over 40 states. The Council members furnish prosthetic devices, which are devices which replace all or part of an internal body organ. We also supply prosthetics and orthotics, surgical dressings, and splints and casts. All these products are furnished to nursing home residents pursuant to physician authorization.

Health care has been the hot topic of discussion for several months now. The Administration has taken steps which it believes will help curtail the monstrous health care costs and at the same time reduce the deficit. The acting HCFA administrator, William Toby, outlined the administration's Medicare proposals on March 31, 1993. While the Council supports reforms and most of the ideas of the administration, we do have some serious concerns.

I. Elimination of Presently Covered Benefits to Nursing Home Residents by Reclassifying Orthotics and Prosthetics and Parenteral and Enteral Nutrition (PEN) into Durable Medical Equipment (DME)

Our main concern with the proposal is the decision to eliminate presently covered benefits to nursing home residents by redefining orthotics and prosthetics, as well as parenteral and enteral nutrition, as DME. The majority of patients in nursing homes are not covered by Medicare Part A. Under the current statutes, orthotics and prosthetics are reimbursed in a nursing home setting while DME is not because the nursing home does not qualify as the patients home. Should orthotics and prosthetics be "lumped" into DME, they will not be paid for in the nursing home. This causes several problems for beneficiaries, nursing homes and suppliers. First, because the coverage of orthotics and prosthetics and PEN will not be paid for in a nursing home setting, the administration is eliminating benefits which beneficiaries currently receive.

Second, many nursing homes would be forced to deny admittance to many patients because they could not pay for many of the non-typical products and services now provided to their residents and paid for under the Medicare Part B program. Many of these presently covered products are specialized, only used by anywhere from 2 to 15% of a facilities residents and require specialized knowledge by the facilities nursing personnel to apply and use.

Third, the cost of the products will fall on the patient and the patient's family. Thus the patient's liability will increase because they will have to absorb the cost of the supplies in the cost of the nursing home. Patients are already paying large sums of money for the care they receive at nursing homes and should not have to incur the additional cost of the supplies needed as well. These added costs will extinguish the patient's assets sooner, making the patient eligible for Medicaid, thus increasing the cost to the Medicaid system.

Fourth, in cases where such patients are continuing to be serviced by the facility, the nursing homes will have to pay for the products as part of their costs, even though they do not have the extra funds to pay for these products. Therefore, the patients may stay longer in acute care hospitals, which are reimbursed for DME, and not be admitted to the nursing homes, which are not reimbursed for DME. This will cause the Medicare system to pay significantly more money should the hospital stay be longer. The current trend of hospital discharges to nursing homes, which are becoming more skilled, has reduced acute care bills substantially. This trend will reverse when nursing homes are forced to increase costs (to include the cost of the supplies) for these highly skilled patients who generally require enteral therapy, catheters and other life maintaining benefits. Should the administration's proposal to lump orthotics and prosthetics into DME be implemented, it will decrease the incentives to take the acute or skilled patient in the nursing home.

Another concern is folding enteral and parenteral nutrition into DME. You have to realize that supplier services include clinical nutritional assessment, timely emergency delivery and allocation, accurate and sophisticated billing mechanisms (generally electronic services), and patient training programs. These services will be eliminated if reimbursement for enteral therapy is discontinued under Medicare Part B for patients residing in skilled nursing facilities - which is the administration's proposal.

II. Electronic Billing

The administration proposed an electronic billing incentive. The Council of nursing home suppliers supports this position and feels electronic billing, as opposed to paper claims, will save money in administrative costs. However, the question is then raised: will there be a $1.00 charge for resubmission of claims? Due to carrier guidelines, if a claim needs to be resubmitted for any reason, even carrier error, a supplier has to resubmit the claim in paper. The Council believes that there should be a system available to resubmit electronically or suppliers should not be charged for the resubmission of the denied claims.

III. Medical Need of Overused Items Approved In Advance of Delivery

The Council believes that the Administration's proposal to require that the medical need of overused items be demonstrated in advance of delivery of patients should apply to DME only. Orthotics and prosthetics (including prosthetics devices and PEN) are disposable, generally sterile, necessary supplies which are provided to patients immediately. DME may be "comfort items" which help maintain a patient's dignity. If a patient does not receive a prosthetic device immediately, the body will cease to function or there will be increased complications.

For example: (1) Catheters, which drain the bladder, often are pulled out of a patient, by the patient. If the allotment in a particular state is two per month, and the patient has received their "allotment", the patient cannot wait for Medicare to approve the third in order to have their bladder drained. (2) If a Doctor orders a patient to receive 2400 calories of a nutrient per day by tube feeding on a Friday, and the carrier has set the caloric parameter at 2000 calories a day, according to the proposal, if the Doctor is unavailable to "demonstrate" the medical need" the patient would not receive the nutrient until the Doctor could demonstrate the medical need. However, a patient who requires the nutrients by a feed tube cannot be denied the product to wait on the Doctor to give a reason why he/she prescribed 2400 calories. However, a patient who requires a walker, a wheelchair etc. can wait for a physician to demonstrate the medical need of the item. This is where DME differs from orthotics and prosthetics: a patient in need of DME can wait for the medical need to be demonstrated. A patient in need of orthotics and prosthetics may be unable to wait on physician clarification before receiving a product which could be necessary for survival (i.e. nutrients).

IV. Recommendations

The Council of Nursing Home Suppliers has always advocated a "level playing field". In order to achieve this "level playing field" for both beneficiaries and suppliers we feel that the Administration should implement three things: (1) national uniform coverage guidelines, (2) national uniform utilization screens, and (3) national uniform reimbursement rates for prosthetics and orthotics. This will save the administration money because such coverage and payment variations encourage companies to forum shop or even legitimately set up business operations in states whose carriers permit higher reimbursement levels and greater utilization. From the fraud and abuse standpoint, if everything is equal, there will be less benefit and more risk to conduct fraudulent practices.

Mandating national reimbursement rates for prosthetic devices is consistent with the Congress's earlier move to national fee screens for parenteral and enteral nutrition (PEN) supplies, and the transition to "national" payment rates with regional variations for durable medical equipment (DME). Since CNHS members market nationally, CNHS members favor the adoption of national fee screens, similar to PEN reimbursement, rather than the DME model. Although DME reimbursement is moving to national payment rates, this system does not truly have national uniform payment rates, because the rates reflect some regional variations.

The Council of Nursing Home Suppliers, as previously stated, supports the administration's proposal to implement electronic billing incentives. We believe a great deal of money can be save at the administrative end.

V. Conclusion

The Council of Nursing Home Suppliers generally agrees with the administration's proposal but feels that the DME portion is too vague and needs to be supplemented.

Mr. Chairman and members of the Subcommittee, we thank you for the opportunity to present our views. We are always willing to be of help to you and your staff.

This concludes my statement. I will be happy to answer any questions that you or members of your Subcommittee may have.

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STATEMENT OF THE
RENAL PHYSICIANS ASSOCIATION
TO THE
ENERGY AND COMMERCE
SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT
U.S. HOUSE OF REPRESENTATIVES
FOR THE RECORD OF THE HEARING
MARCH 31, 1993

RE: MEDICARE PART B AND END-STAGE RENAL DISEASE (ESRD) SERVICES

The Renal Physicians Association (RPA) is taking this opportunity to provide a statement to the Energy and Commerce Subcommittee on Health and the Environment for the record of the March 31, 1993 hearing on Medicare Part B.

RPA is the professional organization of nephrologists whose goals are to insure optimal care under the highest standards of medical practice for patients with renal disease and related disorders. RPA acts as the national representative for physicians engaged in the study and management of patients with renal disease.

Our comments will focus on the President's budget proposals and related matters which affect Medicare Part B and End-Stage Renal Disease (ESRD) services.

Health Care Reform and Consideration of Benefits for Inclusion in a Standard Health Benefit Package

As you are well aware, the President's Health Task Force chaired by Hillary Rodham Clinton is in the process of developing a standard benefit package for all Americans. With health care reform closer now than ever, the RPA is very concerned that the standard (basic or comprehensive) benefit package offered in any health care reform proposal specifically include all medically necessary renal related services including dialysis and renal transplantation.

The Medicare End-Stage Renal Disease (ESRD) program covers almost 93 percent of ESRD patients or approximately 150,000 individuals. While this program should remain intact as part of health care reform[1], there are a growing number of individuals who are not eligible for the Medicare ESRD benefit but who need ESRD services[2]. We believe it is therefore necessary to cover these individuals under the standard package. RPA would urge this committee to ensure that all Americans are covered for medically necessary renal related services including renal dialysis and transplantation either through the Medicare ESRD program or through a standard benefit package that all health plans or employers would have to provide.

Payment Reduction for Erythropoietin (EPO)

Erythropoietin or EPO is a pharmaceutical used by patients suffering from kidney failure to counter anemia by increasing the body's production of red blood cells. EPO has allowed many dialysis patients to return to work and/or to lead more normal and fuller lives. Nephrologists, dialysis facilities, hospitals, and patients all need to purchase this drug because of medical need in the various settings in which this drug is administered.

Under the President's proposal as well as HR 21, Medicare payments for EPO would be reduced from $11 to $10 per 1,000 units. While we understand that this payment reduction is directed at the drug's manufacturer, RPA is concerned that this reduction not be passed on to patients and providers in the form of higher prices. Individual nephrologists and dialysis facilities are not in a position to negotiate rates with the manufacturer or suppliers, let alone patients. We must pay whatever the drug company or supplier charges.

Medicare expects nephrologists and dialysis facilities to pay for EPO from capitated rates which are already in need of desperate updates (see related discussion below on the need to increase the composite rate). These are the Monthly Capitated Payment (MCP) rate paid to nephrologists for treating dialysis patients in the outpatient setting (the subject of another paper), and the Composite Rate paid to dialysis facilities for outpatient maintenance dialysis treatments and related services (see below). While nephrologists and dialysis facilities pay for EPO to administer to patients, some patients do also purchase the drug fully out of pocket for home administration.

The issue of drug pricing and its impact on access is a complicated one. The RPA cannot claim that this proposed reduction would impede access to EPO, but we would urge this Committee at the very least to direct HCFA to closely monitor and annually report on access to EPO if this reduction in the EPO rate is enacted.

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[1] Although an assessment of the Medicare ESRD program within a new health care system should follow, the program could now serve as a model for health care reform. With prospective capitated payments for dialysis related physician services and treatments, the ESRD program is a model of cost effective managed care. In fact, according to HCFA's own data, per patient costs have decreased over time. This virtual single payer system (for a specific disease) has contained costs, expanded access to quality care and lengthened life expectancy.

[2] Kidney Failure and the Federal Government, Institute of Medicine (1991).

Extending and Altering the Medicare Secondary Payor Provision for ESRD Beneficiaries

The President's proposal calls for permanently extending the Medicare Secondary Payer (MSP) provision for ESRD patients from 12 to 18 months. This extension would otherwise expire in January 1996. Last year's Medicare package as included in HR 11 would have extended this provision to 24 months through 1995 for ESRD patients. During these initial periods, employer provided group health plans are expected to serve as primary payer for ESRD related medical expenses before Medicare would kick in.

The President's proposal would also make uniform all the other MSP provisions which affect not only ESRD beneficiaries, but also the aged and disabled. The plan would make all employer thresholds consistent with the aged provision which is 20 or more employees. That is, all employers with 20 or more employees with a group health insurance plan would be required to act as primary payer for its aged, disabled, and Medicare ESRD entitled employees for specified amounts of time. This requires a reduction in the disability provision from 100 to 20 employees and the creation of a 20 or more employee threshold for ESRD beneficiaries. Currently, all employer health plans, regardless of the number of employees, are required to serve as primary payers for beneficiaries who have become entitled to Medicare solely because of ESRD (as opposed to becoming entitled because of age or disability).

Lastly, the President would also eliminate the exemption from the MSP provision for individuals with ESRD who are also aged or disabled. Payments for these individuals would be treated the same as with payment for beneficiaries entitled to Medicare solely because of ESRD.

A recent interim General Accounting Office (GAO) report[3] which studied the effects of the OBRA '90 ESRD MSP extension from 12 to 18 months, showed that the extension appeared to have negatively affected some beneficiaries' or their spouses' access to and retention of employment or employer health insurance. Although the numbers are relatively small this is cause for concern especially since the sample size was limited. A broader study should be conducted before Congress decides to make this extension permanent. In addition, the GAO's study of the effects of this provision is not completed. The GAO has yet to report on beneficiary out of pocket expenses and other issues, expected to be completed in January 1995.

Since we do not know yet what President Clinton's health care reform proposal will look like, it is difficult to speculate on how this provision will affect ESRD patients under a new health care system. ESRD patient and spousal access to health insurance (and job discrimination) is an issue that should be analyzed within the context of the President's health reform plan.

Extending the Physician Ownership and Referral Ban

President Clinton's economic package would extend the current ban on Medicare physician ownership and referral to outside clinical laboratories to other services including: physical and occupational therapy; radiology and other diagnostics; radiation therapy; durable medical equipment, and parenteral/enteral nutrition equipment and supplies. There have been similar proposals by Congressman Stark and others to also extend the current ban.

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[3] Medicare: Millions in End-Stage Renal Disease Expenditures Shifted to Employer Health Plans, United States General Accounting Office Report to Congressional Committees (December 1992).

RPA is fully supportive of efforts to eliminate unethical referral arrangements by physicians. Although the President's provision in this area does not include renal dialysis facilities, RPA would like to ensure that any bill passed by the Congress in this area exclude nephrologist owned renal dialysis facilities because **dialysis centers are an extension of the nephrologist's medical practice**. This is clearly recognized within the medical community. Unlike most referral facilities, dialysis provides a therapeutic service and is not used for diagnostic purposes. Dialysis facilities only serve patients with irreversible kidney failure who must receive dialysis to maintain their lives. Dialysis is not an elective procedure and its medical necessity cannot be questioned.

Legislation which would blanketly ban self referral arrangements by physicians should explicitly exclude renal dialysis facilities. The following legislative language is suggested by the RPA:

> Nonreferrals. The following shall not constitute a referral by a referring physician: a referral by a physician, or by a member of his or her group, to a renal dialysis provider in conjunction with a renal dialysis procedure performed under the supervision of the physician or by a member of his or her group.

Increasing the Composite Rate Paid to Dialysis Facilities

The Prospective Payment Assessment Commission (ProPAC) has recommended to Congress that the composite rate for dialysis facilities be updated by 2.5 percent for FY 1994. The RPA fully supports this long overdue update and urges Congress to enact this recommendation. As you may know, the composite rate paid to renal dialysis facilities for outpatient maintenance dialysis treatments and related services under Medicare has essentially been either frozen or reduced since the rate was established in 1973 with the exception of a $1 increase per dialysis treatment in 1991. Even with this $1 increase in 1991, the composite rate has dropped over 60 percent in real dollars because of explicit freezes and rate reductions and the unadjusted effects of inflation[4] since 1974.

It is true that there were some productivity increases in the 70s and part of the 80s which allowed many dialysis facilities to operate successfully with the established rate, but reports about jeopardizing quality of care under these real dollar decreasing rates, especially from such notable sources as the Institute of Medicine[5], is cause for alarm.

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[4] See Kidney Failure and the Federal Government, Institute of Medicine (1991); and Committee on Ways and Means, U.S. House of Representatives, Background Material and Data on Programs Within the Jurisdiction of the Committee on Ways and Means (aka: the Green Book), (1992 Edition).

[5] ibid.

While there is not as much available and reliable data upon which to make a decision in this area as some would like, it is clear that some update is called for. A 2.5 percent increase in the composite rate as recommended by the ProPAC would at least provide in part for inflation and the extra costs associated with EPO, and the new regulatory burdens of CLIA, OSHA and ADA. With these extra costs and the fact that the rate has not been evaluated or updated in 20 years (with the exception of the $1 dollar per treatment increase in 1991), a 2.5 percent increase is modest in any terms.

RPA's concerns about the quality of patient care is number one on our agenda. We are involved in practice guidelines research and development and are working with the Agency for Health Care Policy and Research (AHCPR) and the National Institute of Diabetes, Digestive, and Kidney Diseases (NIDDK). Our efforts are also integrally connected with the U.S. Renal Disease Data System also known as the ESRD Patient Registry. A 2.5 percent update in the composite rate, as recommended by ProPAC, would certainly help renal dialysis facilities to maintain (and possibly improve) the quality of care provided to ESRD beneficiaries.

Reduction in the Medicare Volume Performance Standard and Update Default Formula

The purpose of the President's proposal in this area is to reduce the amount of increases in physician fees in future years. The plan would reduce the Medicare Volume Performance Standard (MVPS) default formula and the default update for Medicare payments to physicians.

RPA supports the need to amend the VPS formula established by Congress in OBRAs 89 and 90. Last year, the RPA urged Congress to preclude an almost four times higher and separate update for surgery than for non-surgery including primary care that would occur under the default formula. Unfortunately, Congress adjourned without taking any action to prevent this higher update for surgery from going into effect in 1993. The result is, unless Congress acts to correct the problem now, surgical services will permanently have a higher dollar conversion factor update than non-surgical services including primary care visits and other evaluation and management services.

The President's proposal provides an opportunity to correct this flaw. Instead of lowering the default VPS equally for all services, as the President's proposal would do, RPA would urge Congress to either support a single VPS for all services, or create a separate and higher VPS for EM services and a higher default update for primary care services including office, nursing home, and home visits.

The Physician Payment Review Commission, in its upcoming report to Congress will be recommending a similar approach. If separate VPSs are to be maintained says the PPRC, then EM services should be given improved treatment by being placed under their own VPS.

Exempting Primary Care From Any Reductions in Physician Fees in 1994

RPA fully supports the Administration's plan to exempt primary care from the reductions proposed for all other physician services. The President's proposal would reduce the current law Medicare conversion factor by two percent for all services except primary care. If these reductions are taken at the same time the Medicare update is provided based on the current MVPSs (which we understand is the Administration's intent), this proposal would in effect provide primary care with a full conversion factor update while reducing the amount of the update for all other services.

While RPA is pleased with the Administration's efforts to protect primary care, it must be noted that because primary care is lumped in with non-surgery in the current law VPS, surgery may still receive a higher update than primary care services even under this approach proposed by the President (see related discussion on the altering the default VPS and update above). Nevertheless, the President's proposal would represent the first time in three years that primary care has received an update equal to inflation. By contrast, the 1993 update for primary care services was only 0.8 percent, compared to 3.1 percent for surgery -- the exact opposite of what should have occurred to promote and encourage primary care.

The President's plan appears to recognize that if cuts in Medicare are required, they should not negatively impact on primary care services. RPA would urge Congress to uphold the President's approach by providing a full 1994 fee schedule update for primary care services, and to reject calls for an across the board reduction that will be presented under the guise of "fairness." Similarly, if Congress entertains the idea of delaying the update entirely for a period of six months, for example, keep in mind that such a delay continues to perpetuate the almost four times higher and separate update for surgery (than for non-surgery including primary care) that took place in 1993. In addition, if a delay in the update is sought (which is obviously not the preferred approach), it should be enacted only on the condition that primary care services receive the full update at the end of that period.

Resource-Based Practice Expenses for the Medicare Physician Fee Schedule

The Administration is proposing to begin phasing in a resource-based practice expense index for the Medicare Fee Schedule beginning in 1997. To cut the deficit, the proposal also calls for reductions in practice expense relative value for certain services in 1994, 1995, and 1996. According the President's plan, practice expense values would be reduced for services if the practice expense value exceeded the work value for a particular service.

RPA supports the idea of a fully resource based relative value scale. However, we are troubled by this proposal for several reasons. First, the President's method to reduce practice expense values is completely arbitrary. Why would the fact of having a practice expense value greater than the work value suggest that the practice expense value is overvalued and should be reduced? Although this arbitrary method would move many practice expense values closer to where they would be under a resource-based practice expense index, some may be cut to deeply, and others may be cut entirely without cause or reason resulting in a skewed RBRVS.

Second, there is still research that needs to be done, data to be collected, and questions to be answered, before a decision on an appropriate methodology for a resource-based practice expense index can be made and implemented -- even the Physician Payment Review Commission and the Health Care Financing Administration would admit this. Third, RPA is concerned about disrupting the initial current phase in of the fee schedule which will not be completed until 1997.

Fourth, while we understand that physicians must do their share to contribute to reducing the federal budget deficit, we would feel somewhat betrayed if the RBRVS was used merely for budgetary reasons, disregarding its original intent: namely to redistribute payments away from overvalued procedures to undervalued services such as office visits. Office visits and other evaluation and management services have practice expense components which remain undervalued.

If Congress decides to pursue the President's plan in this area, then it would be wise to also devise a mechanism (equally arbitrary) whereby undervalued services including primary care would see increases in their practice expense values at the same time overvalued services received decreases. Otherwise, the RPA would recommend not to tinker with the RBRVS until such time as a sound methodology is developed and better data collected on resource based practice expenses. The PPRC believes that this will occur by 1997 and thus has recommended that resource-based practice expenses be implemented at that time.

MEDICAID BUDGET RECONCILIATION

THURSDAY, APRIL 1, 1993

House of Representatives,
Committee on Energy and Commerce,
Subcommittee on Health and the Environment,
Washington, DC.

The subcommittee met, pursuant to notice, at 9:52 a.m., in room 2123, Rayburn House Office Building, Hon. Henry A. Waxman (chairman) presiding.

Mr. Waxman. The meeting of the subcommittee will come to order.

Today's hearing is about reducing spending in this Nation's largest health care program for the poor, Medicaid. As requested by the administration, the fiscal year 1994 budget resolution directs this committee to reduce Federal Medicaid outlays by $7.8 billion over the next 5 fiscal years, the largest cut in Federal Medicaid spending since 1981.

Yesterday we heard the administration testify how they would achieve these budget reductions. They urge five policies. First, they would repeal the requirement scheduled to take effect in 1994, that States cover personal care services for elderly and disabled beneficiaries who will otherwise be institutionalized. Second, they would reduce Federal matching payments for high priority administrative activities like nursing home inspections and fraud and abuse control. Third, they would take steps to prevent individuals from transferring assets in order to qualify for Medicaid coverage for nursing home care. Fourth, they would remove the current prohibition on the use of restrictive drug formularies by States. Finally, they would establish a central clearinghouse to identify third parties that are liable for care delivered to Medicaid beneficiaries.

The Congressional Budget Office has reviewed these proposals and submitted formal estimates to the subcommittee. According to CBO, the administration's proposals would reduce Federal Medicaid outlays by $7.915 billion over the next 5 years, and, without objection, these estimates will be inserted in the record at this point.

Congressional Budget Office Estimates of Medicaid Provisions in President's Budget

[March 23, 1993]

	1994	1995	1996	1997	1998	5-year total
Outlays by fiscal year in millions of dollars:						
Medicaid 50 percent Admin, Match	−140	−325	−365	−410	−460	−1,700
Personal Care Services	0	−850	−980	−1,100	−1,240	−4,170
Estate/Asset Rule	−75	−150	−250	−375	−450	−1,300
Drug Formularies	−15	−40	−50	−55	−65	−225

Congressional Budget Office Estimates of Medicaid Provisions in President's Budget
Continued
[March 23, 1993]

	1994	1995	1996	1997	1998	5-year total
Third party liability	0	−65	−105	−165	−185	−520
Total Direct Spending	−230	−1,430	−1,750	−2,105	−2,400	−7,915

Notes: Estimates based on descriptions of proposals in OMB document of February 17, 1993 entitled "A Vision of Change for America", and conversations with administration staff.

Mr. WAXMAN. In adopting the Clinton administration's outlay target, the House Budget Committee did not accept the administration's specific proposals. In fact, the Budget Committee expressed its concern that the administration's proposal to reduce enhanced administrative matching rates would seriously undermine the ability of States to carry out federally mandated activities. The Budget Committee encouraged this committee to develop alternative policies to reach the reconciliation targets, with the expectation that every effort will be made to avoid burdening States and beneficiaries.

In today's hearing, the subcommittee will focus on four of the administration's proposals: the repeal of the personal care mandate, the reduction of administrative matching rates, tightening transfer of assets and recovery procedures, and removal of the prohibition against drug formularies.

The acting director of HCFA, Mr. William Toby, testified yesterday that these proposals were designed "to provide immediate relief to the States and Federal Government from inappropriate or outdated policies." He also argued that the proposals were aimed at inefficiencies and were intended to promote cost effectiveness.

It is not entirely clear whether these proposals will have the intended results. For example, how will reducing Federal matching payments for fraud control and management information systems promote cost effectiveness in this program?

Today's hearing will also explore whether there are alternative ways to reduce Federal Medicaid spending over the next 5 years by $7.8 billion. We want to be certain that we follow the Budget Committee's directive to make every effort to avoid shifting costs to the States or cutting benefits or eligibility.

Before recognizing our witnesses today, I want to call on members of the subcommittee for opening statements, and let me ask that we give unanimous consent that all members may have an opportunity to insert an opening statement at this point in the record.

Mr. Klug.

Mr. KLUG. I have no opening statement, Mr. Chairman.

[The opening statement of Hon. Mike Kreidler follows:]

OPENING STATEMENT OF HON. MIKE KREIDLER

Mr. Chairman, I share your concern about some of the proposals we are hearing in the Medicaid program. Medicaid may be one of the fastest-growing programs in our budget, but it is also one of the most important. Until we have real health care reform, that guarantees comprehensive coverage to everyone in this country, we have to be very careful to maintain the safety net that Medicaid represents.

Coming here after 16 years struggling with a State budget in the Legislature, I understand the administration's concern about rising Medicaid costs. But I also have real concerns about shifting those costs to the States by reducing matching rates for administrative functions. I think you are right on target, Mr. Chairman, in pointing out the danger of cutting back on fraud control units, computerization, and the other functions the States perform to control their own costs and ours.

Mr. WAXMAN. To help put these Medicaid budget cuts in a broader context, our first panel will give us a brief overview of the role of the program in financing medical and long-term care for the poor and the reasons for the increases in program costs.

Our witness is Trish Riley, a member of the Kaiser Commission on the Future of Medicaid. The 15-member Commission was established by the Henry J. Kaiser Family Foundation in 1991 to function as a Medicaid policy institute and as a forum for analyzing and proposing program reforms.

Ms. Riley is superbly qualified to help us understand this budget reconciliation process and the larger Medicaid context. She has 15 years of experience in State government, including service as the Medicaid director in the State of Maine.

Ms. Riley, we want to welcome you to our subcommittee hearing today. Your prepared statement will be inserted in the record in full. Because of the large number of witnesses we have to testify before us, we would like to ask you to limit your oral presentation to no more than 5 minutes. And, for those of you who have testified before the subcommittee, we do have a timer. The bell will go off in 5 minutes, and we would appreciate at that point the witnesses would conclude their oral presentation.

STATEMENT OF TRISH RILEY, ON BEHALF OF KAISER COMMISSION ON THE FUTURE OF MEDICAID

Ms. RILEY. Thank you, Mr. Chairman, members of the committee. It is a pleasure to be here.

Since our inception in 1991, the Kaiser Commission on the Future of Medicaid has come to characterize Medicaid as three complex and discrete programs in one. Providing a safety net for 31 million Americans, Medicaid provides coverage to more than one in 10 of our citizens.

First, the program provides basic medical coverage to children and adults in low-income families who are outside our employment-based insurance system. Medicaid is a major insurer of children. It covers 20 percent of all children, nearly one-third of all infants, nearly two of three children in poor families. These families make up 73 percent of Medicaid beneficiaries but account for only 30 percent of our costs.

Second, Medicaid covers elderly in two ways. First, it makes Medicare work by paying costly premiums and cost sharing for beneficiaries too poor to pay themselves. Second, it is virtually the only payer for long-term care. In 1990, 45 percent of the $53 billion spent on nursing homes was by Medicaid; 49 States have attempted to provide community-based options through Medicaid waivers, but even these strategies are limited.

Finally, the third element to the Medicaid program is its coverage for acute and long-term care services for people with disabilities. This diverse group includes special needs children, younger citizens with physical and mental disabilities, and people with

AIDS and other chronic illness. Here, too, Medicaid's institutional financing is clear. Nine out of 10 Medicaid beneficiaries who are disabled live in the community, but over one-half of all expenditures support institutions.

As the Nation's health care safety net, Medicaid faces continuing pressure to improve and expand the protection it provides, yet the program also faces annual cost increases that stagger its Federal and State finances and undermine its ability to meet growing needs. Medicaid's spending grew 30 percent in 1 year from 1991 to 1992, reaching $120 billion, yet only 4 percent of its expenditures are spent on administrative costs. It is important to recognize that 96 percent of Medicaid dollars go to direct services.

A Kaiser Commission study of the spending growth between 1988 to 1991 finds that national spending on Medicaid services grew by $37 billion. Three factors, all about of equal weight, contribute to that growth. The first two, accounting for about two-thirds of the increase, are reflective of our broader health care crisis. First, uninsured have become eligible for Medicaid; and, second, medical inflation affects Medicaid as it does all other payers. The third factor is more specific to Medicaid and is accounted for by increases in spending per beneficiary. Let me say just a bit about each.

Growth in Medicaid enrollment accounted for 34 percent of Medicaid's cost increases from 1988 to 1991. In that period, 4.8 million new beneficiaries entered the program. Half of these new beneficiaries were pregnant women and children, but of that large percentage of new enrollees, they accounted for only 11 percent of the total growth in the Medicaid program. The remaining half of new enrollees were aged people with disabilities and those with families receiving AFDC. Reflecting their higher use of institutions, these beneficiaries account for 19 percent of the growth.

The second factor, medical price inflation, accounted for 31 percent of cost growth from 1988 to 1991, underscoring the fact that Medicaid does not exist in isolation and policies that do not recognize the impact of the medical marketplace on Medicaid could jeopardize the program.

Finally, increases in spending per beneficiary represent 28 percent of the total growth. This factor reflects the influences of growing demand for services from sicker populations, increased payments to providers in part ruling from Boren amendment-related litigation, and increases in State use of alternative financing systems to draw additional Federal dollars, such as provider-related taxes and donations, disproportionate share payments to hospitals, and intergovernmental transfers. Unfortunately, we are not able to determine the costs related to each of these individual strategies due to data limitations.

Limits on the use of alternative financing systems, coupled with decreasing Federal grants to States for other social welfare programs, increase the fiscal pressure States face in providing health coverage to vulnerable populations. Given the economic climate and the growing need for health care assistance, States are faced with limited choices in operating their Medicaid programs. Perhaps more important, however, are the families who rely on Medicaid. For them, their protection is in a precarious situation.

A recent Kaiser Family Foundation study shows that a large share of adult Medicaid beneficiaries had problems meeting basic obligations, including finding a job, paying the rent, and buying food. Equally troubling, the study finds that in the last year 18 percent of adult Medicaid beneficiaries were turned away from physicians and hospitals, 20 percent had to go to emergency rooms because they did not have a regular doctor, and 23 percent had problems paying medical bills.

The findings of this survey all point to the importance of maintaining adequate levels of financing to care for the Medicaid population and indicate that Federal and State leaders may be hard pressed to squeeze significant cost savings out of the $120 billion Medicaid system without further endangering access.

Thank you.

[Testimony resumes on p. 268.]

[The prepared statement of Ms. Riley follows:]

STATEMENT OF TRISH RILEY

Overview of Medicaid: Fiscal Pressure on the Safety Net

Kaiser Commission on the Future of Medicaid

Thank You, Mr. Chairman, for this opportunity to testify on behalf of the Kaiser Commission on the Future of Medicaid. My name is Trish Riley and I serve as a member of the Commission. The Kaiser Commission was established in 1991 to function as a Medicaid policy institute and to serve as a forum for analyzing, debating, and proposing future directions for health care for poor and vulnerable populations. I am here today to provide an overview of the critical importance of the multiple roles Medicaid plays as a safety net for the low-income people it serves and to share the results of a recent Commission study on the recent rise in Medicaid spending.

Today, Medicaid is at a critical juncture. Since its enactment in 1965, the program has been on the front lines in meeting the health needs of our country's most vulnerable. Medicaid provides health insurance protection to those who fall outside traditional employment-based coverage--the poor and the very disabled--and offers a broad scope of benefits to address their diverse health and complicated social needs. However, limitations in basic program design and financing now threaten to undermine the extent to which Medicaid can continue to function as the safety net and evolve to meet the needs of those it serves.

Established as a federal and state partnership, Medicaid is financed with state revenues and matching federal payments and is administered by the states. In order to become eligible for Medicaid, an individual must meet both categorical and income requirements. Program management is complex and its administrative responsibilities have had to expand in response to federal legislation requiring new outreach enrollment practices, as well as frequent changes in program eligibility and data system requirements. In spite of these pressures, administrative costs have remained at around 4 percent of total spending. This rate is significantly lower than that of the private sector and on par with that of Medicare. Ninety-six percent of Medicaid dollars are spent directly on services to low-income families and elderly peoples as well as people with disabilities that rely on Medicaid for access to health care services.

The Medicaid Safety Net

From its beginnings as a health care financing program primarily for welfare recipients, Medicaid's responsibilities have gradually expanded and become more complex. Today, Medicaid is a key provider of health insurance for low-income families, supplementary insurance for low-income Medicare beneficiaries, and long-term care services for the elderly population and people with disabilities. In 1991, Medicaid served nearly 28 million people, providing assistance to over one in ten Americans. Enrollment in 1992 was approximately 31 million beneficiaries. However, because of stringent income and categorical requirements, slightly less than half of the poor have Medicaid coverage.

As the program's scope has expanded, so have its costs, creating tremendous pressures on the states and the federal government to find the funds for Medicaid's growing obligations. Medicaid finances 12 percent of total health spending at a cost of $92 billion in 1991. The findings I will present are drawn from the Kaiser Commission's first report, *Medicaid at the Crossroads*. It is our hope that the information presented in that report will contribute to the general understanding of the pressures facing Medicaid as well as the important roles that Medicaid plays for the populations it serves.

Medicaid's Role for Low-Income Families

In our employment-based health insurance system, those outside the work force or in low-wage or part-time employment generally cannot afford to buy health insurance. For children and adults in low-income families who qualify, Medicaid provides health insurance, covering basic medical services, just as private insurance does for higher income families. Because the population served by Medicaid has higher infant mortality rates and lower birthweight babies and lower overall health status than higher-income individuals, Medicaid coverage of basic primary care and preventive services is particularly important.

Crucial to the well-being of America's young, Medicaid is a major health insurer of children, covering 13 million or 20 percent of all children and nearly one third of all infants. Medicaid assistance is particularly critical to poor children, with nearly two out of three youngsters in poor families receiving Medicaid assistance.

Medicaid covered 19.6 million children and their parents at a cost of $26.1 billion in 1991. Low-income families comprise 73 percent of Medicaid's beneficiaries, but account for less than 30 percent of program spending (Exhibit A). This population utilizes mostly primary care and less expensive services, in contrast to others on Medicaid who rely more heavily on costly hospital and nursing home care.

Recognizing the importance of early and continuous prenatal care and that poor women are especially at risk for receiving inadequate prenatal care, Medicaid eligibility for pregnant women has been significantly expanded in recent years. Twenty four states have raised eligibility for pregnant women and infants beyond the federally mandated level of 133 percent of poverty to the optional level of 185 percent. In the face of growing fiscal pressure, however, states may be forced to retrench, rolling back expanded eligibility levels to 133 percent of poverty.

Medicaid's Role for the Elderly

For the low-income elderly population, Medicaid plays a dual role -- that of a supplement to Medicare and that of a payer of long-term care, covering institutional and community-based services. In 1991, Medicaid spent $28.6 billion to cover 3.4 million elderly persons.

Although virtually all people over 65 have Medicare as their primary insurer to cover basic medical needs, Medicare requires beneficiaries to pay a share of service costs and leaves some essential medical services, including prescription drugs and vision care, uncovered. Today, Medicare cost sharing requirements are steep, including a Part A hospital deductible of $684 per stay, a Part B premium of $439 per year and deductible of $100 per year, as well as 20 percent cost sharing for physician and other medical services.

Most elderly persons purchase private medigap insurance to cover these expenditures. Because low-income elderly people cannot afford to purchase private medigap coverage or even to pay for the Part B premium, they rely on Medicaid to fill this role. Medicaid functions as medigap for the low-income elderly, covering Medicare's cost-sharing and premium requirements, as well as additional medical services including prescription drugs, vision and dental care, and long-term care services. Recently, legislation has expanded Medicaid coverage of the Medicare premium and cost-sharing requirements to assist more low-income elderly people, but participation rates among the elderly remain low. Nonetheless, for those with Medicaid coverage, Medicaid makes Medicare work. Clearly, the availability of Medicaid coverage is critical to the welfare of the low-income Medicare population.

For the elderly population with disabilities, Medicaid plays yet a different role. It is virtually the only payer for institutional and community-based long-term care other than direct of-pocket payments by the elderly and their families. Medicare does not provide long-term personal care, either to persons in the community or to those residing in nursing homes. Furthermore, adequate private insurance coverage is only beginning to become available for these services.

Medicaid can be an essential source of in-home assistance, enabling elderly people with disabilities to remain in the community. Through the availability of home- and community-based waivers, 49 states have implemented innovative programs to deliver community-based services as an alternative to nursing home care. Care received at home is preferred by the majority of elderly people with disabilities and their families and results in improvements in quality of life at a lower cost than nursing home care. However, states must meet stringent requirements to obtain waiver approval, precluding many states from taking full advantage of this program. As a result, home- and community-based services are currently not uniformly available on a statewide basis to all those who are eligible and may benefit.

Despite the growing attention to the benefits of community care, Medicaid continues to play a fundamental role for institutionalized elderly people, financing 45 percent of the $53 billion spent on nursing home care in 1990. Nursing home care is expensive, often exceeding $30,000 a year. Regardless of whom it affects, it is a catastrophic expense that is likely to impoverish most middle- and lower-income persons. Medicaid is the only source of financing other than personal payments and plays an essential role by providing coverage for nursing home stays for people with limited income or who have depleted their income and resources. Recently enacted legislation protecting against the impoverishment of a spouse living in the community due to the costs of nursing home care may have broadened the use of this benefit.

Medicaid's Role for People with Disabilities

The people with disabilities under 65 years old make up the most diverse Medicaid beneficiary group and have equally disparate needs. Children with spina bifida, teenagers and adults who are mentally retarded, persons with AIDS, the chronically mentally ill, and permanently injured adults are just a few of the many faces of the Medicaid beneficiaries with disabilities. For low-income people who are receiving cash assistance through Supplemental

Security Income, Medicaid covers basic medical services, as well as long-term care in the community and institutions.

Medicaid provides medical and long-term care coverage for 4.0 million nonelderly people with disabilities at a cost of $31.1 billion. Representing 15 percent of beneficiaries, people with disabilities consume 35 percent of program spending. Although nine out of ten Medicaid beneficiaries with disabilities live in the community, care for the institutionalized consumes over half of all Medicaid spending for this group.

In sum, Medicaid provides critical assistance with the costs of medical and long-term care services for the poor and the very disabled, with only a small fraction of Medicaid expenditures going towards administrative functions. Because it plays so many different roles for the populations it serves, spending for each group is not uniform. Average annual per beneficiary spending is $1,086 for children and $1,844 for adults compared to $8,524 for the elderly and $7,789 for people with disabilities (Exhibit B). As a result, nearly three quarters of beneficiaries are individuals in low-income families, but they account for only one third of all spending. This is because Medicaid spending is dominated by the elderly population and people with disabilities who require more intensive and costly services.

Fiscal Pressures on Medicaid

Medicaid, the nation's health care safety net, is today at the heart of society's debate over the role and costs of entitlement programs. Medicaid faces continuing pressure to improve or expand the protection it provides -- by covering more of the millions of low-income Americans without insurance and by promoting better access to care for the millions it does cover. Yet the program also faces annual cost increases that stagger its federal and state financiers and undermine its ability to meet growing needs.

The recent rapid escalation in Medicaid spending is a dramatic shift from historical patterns. Medicaid spending has generally grown slightly more slowly than either private health spending or Medicare spending on the aged and people with disabilities. But, over the last four years, total Medicaid spending began to accelerate sharply, increasing 13 percent in 1989, 19 percent in 1990, and 27 percent in 1991. Spending is projected to increase 30 percent in 1992 to $120 billion.

The Kaiser Commission on the Future of Medicaid undertook an analysis to understand the factors driving the increase in Medicaid spending and to assess the implications for future program financing. The findings I will present are drawn from the analysis of Medicaid spending conducted by the Urban Institute for the Commission and are detailed in our report entitled *The Medicaid Cost Explosion: Causes and Consequences.*

From 1988 to 1991, national spending on Medicaid services in the 50 states and the District of Columbia grew from $51.6 billion to $88.6 billion -- an increase of $37 billion. This analysis shows the major determinants of Medicaid spending -- expansions in enrollment, increases in medical price inflation, and growth in expenditures per beneficiary -- each account for roughly a third of the $37 billion increase over this period. A small share is attributable to premium payments to Medicare and to health maintenance organizations (Exhibit C).

Enrollment

Growth in Medicaid enrollment accounted for 34 percent of the increase in expenditures from 1988 to 1991. During this period, enrollment grew from 22.2 million to 27.0 million individuals, resulting in an additional 4.8 million beneficiaries. Half of the new Medicaid beneficiaries were the pregnant women and children covered as a result of state expansions, driven, in part, by federal requirements to broaden coverage for this population. Although they represent the bulk of new enrollees, the costs associated with the coverage of this group account for only 11 percent of total growth in that period.

This finding stands in sharp contrast to the common perception that federal mandates expanding coverage to pregnant women and children have largely been responsible for the cost explosion. In fact, enrollment increases in traditional Medicaid populations such as the aged and people with disabilities, as well as families receiving Aid to Families with Dependent Children (AFDC), represented the other half of the new enrollees, and account for one fourth of total expenditure growth. This reflects the higher costs associated with the acute and long-term care services for the elderly and other beneficiaries with disabilities.

Enrollment growth reflects Medicaid's expansion to cover growing numbers of poor and vulnerable Americans -- the very purpose for which it was established. Contrary to conventional wisdom, only a small proportion of cost growth comes from newly enrolled pregnant women and children, for whom states and federal government have deemed coverage essential. These legislatively mandated expansions are providing needed coverage to millions, but their per capita costs are relatively small. Expanded enrollment among far smaller numbers of persons with disabilities impose much greater per capita costs, which, at this time, only Medicaid is willing to bear.

Medical Price Inflation

Medical price inflation was responsible for 31 percent of the expenditure growth during the 1988 to 1991 period. This factor is outside of Medicaid's control and underscores the fact that Medicaid purchases care for its beneficiaries within the larger health care marketplace. Like all other payers of health care, Medicaid struggles with meeting its responsibilities in the face of escalating health care costs. Policies that attempt to control Medicaid spending in isolation from the rest of the health care system could jeopardize the very protection Medicaid aims to provide.

Increases in Spending per Beneficiary

Increases in spending per beneficiary represent 28 percent of the total growth. This factor reflects the influences of growing demand for services from sicker populations, increased payments to providers, and increases in state use of alternative financing systems such as provider-related taxes and donations to bring in federal dollars. Although these factors are important, data limitations do not permit the disaggregation of spending on these multiple components and preclude the assignment of their relative contributions.

Some of these cost increases reflect increased use of services attributable to the coverage of sicker populations, such as those with AIDS or substance-dependent babies, as well as the provision of enhanced benefits to meet the special needs of these vulnerable populations. In other cases, states have increased Medicaid payment to providers to keep pace with private sector prices and comply with the Boren Amendment regarding the adequacy of hospital and nursing home payments. In response to historically low Medicaid participation rates by physicians and impaired access to care for Medicaid beneficiaries, recent federal legislation has required that reimbursements to pediatricians and obstetricians be sufficient to assure access for low-income children and pregnant women.

Most recently, states have sought to obtain additional federal Medicaid matching funds through the use of alternative financing mechanisms. These strategies have most commonly employed either provider-related taxes and donations, intergovernmental transfers, or increased use of disproportionate share payments to hospitals as revenue raising techniques. The federal funds raised by these methods have been used to finance Medicaid expansions and enhancements or to fund other state activities.

Recent federal legislation limits the states' use of these strategies and will undoubtedly place renewed pressure on already strained state treasuries. This action, coupled with the trend in decreasing federal grants-in-aid to the states for other social welfare programs, increases the fiscal pressure states face in providing health coverage to vulnerable populations. Given the economic climate and the growing need for health care assistance, states are faced with limited choices in operating their Medicaid programs. Constrained by eligibility and benefit requirements and the need to provide adequate payment to safeguard access, states are left with few alternatives. If states are unable to generate sufficient general revenues, they may be forced to make sharp program cutbacks, compromising access to care for the most vulnerable of our citizens.

Medicaid in a Reformed Health Care System

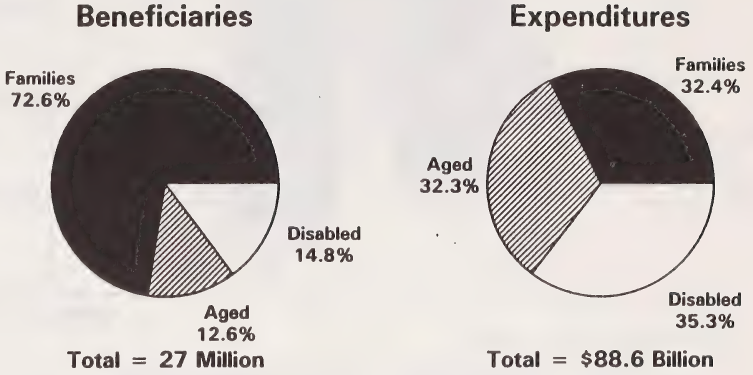
Medicaid is thus a vital source of health care financing for many of America's poorest children and their parents as well as people who are elderly or have disabilities. Without it, they are at risk for delaying necessary care which can result in the exacerbation of treatable conditions, potentially jeopardizing the individual's well-being as well as leading to higher overall costs for medical care.

The families who rely on Medicaid for protection are in a precarious financial situation. A recent Kaiser Family Foundation study shows that nearly half of all adult Medicaid beneficiaries had problems finding a job, nearly one third had difficulty paying the rent, and over one fourth reported problems buying food. Even more troubling, the study finds that in the last year, 18 percent of adult Medicaid beneficiaries were turned away from physicians or hospitals, 20 percent had to go to emergency rooms because they did not have a regular doctor, and 23 percent had problems paying medical bills. The findings of this survey all point to the importance of maintaining adequate levels of financing to care for the Medicaid population and indicate that federal and state leaders may be hard pressed to squeeze significant cost savings out of the $120 billion Medicaid system without further endangering access to care.

With health care reform at the forefront of the national policy agenda, there is a critical need to be sure, whatever program is ultimately implemented, that it includes comprehensive services that meet the numerous and complex needs of the low-income population. As the nation deliberates the development of a system to serve all Americans, it is crucial that the Medicaid services that poor children, pregnant women, people with disabilities, and poor elderly people depend on today are not jeopardized. It is essential that the services that the poor and vulnerable rely upon not be eroded, but be maintained at adequate levels, particularly during any transition period to a reformed health care system. In the interim, reduction in coverage or limits on benefits for those on Medicaid could have catastrophic implications for this population because they are without the financial means to compensate for the gaps in the system. We urge the Committee to examine with particular attention the implications of a transition to a reformed health care system on the Medicaid population. Thank you. I welcome your questions.

Exhibit A

Distribution of Medicaid Beneficiaries and Expenditures, by Enrollment Group, 1991

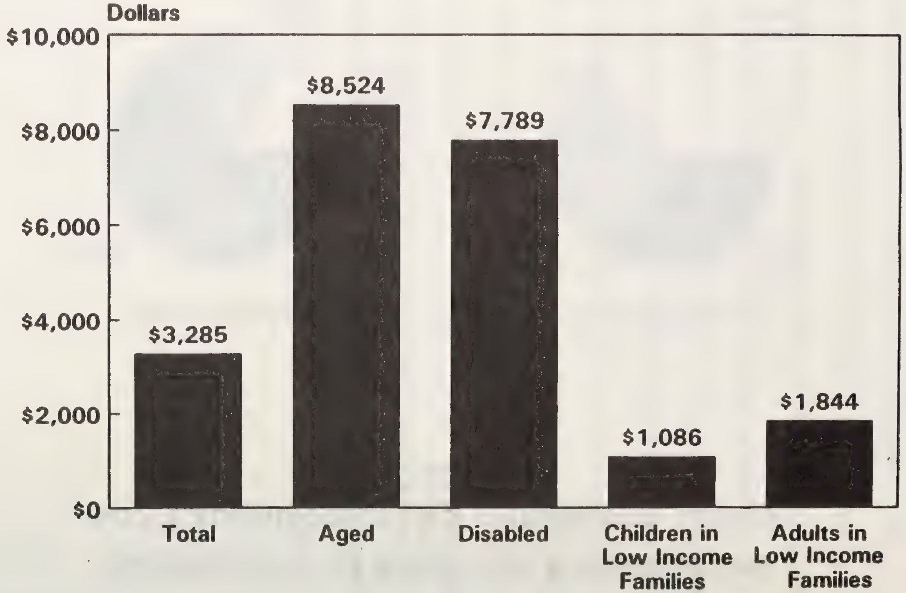


Source: Urban Institute, 1992.

Kaiser Commission on the Future of Medicaid

Exhibit B

Annual Medicaid Payments per Beneficiary by Eligibility Group, 1991

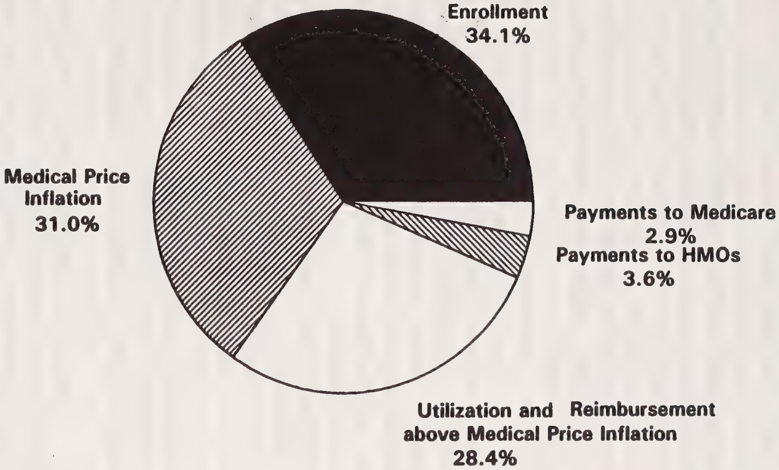


Source: Urban Institute, 1992

Kaiser Commission on the Future of Medicaid

Exhibit C

Factors Contributing to Medicaid Expenditure Growth, 1988-1991



Total = $37 Billion

Source: Urban Institute, 1992.

Kaiser Commission on the Future of Medicaid

Mr. WAXMAN. Thank you very much for that presentation and, I think, a clear exposition of the diversity of what Medicaid provides for low-income people.

In Exhibit C to your testimony, you told us there were three major causes of Medicaid spending growth: the number of poor people eligible, medical price inflation, and utilization and reimbursement above medical price inflation. Will the administration's proposal for reducing Federal Medicaid spending have any significant impact on medical price inflation? Do you believe we can really get a handle on Medicaid costs without attacking medical price inflation across the board?

Ms. RILEY. Mr. Chairman, the Commission does not have a position on the particulars of the administration's proposal, but I think it is abundantly clear that Medicaid plays in the bigger marketplace and efforts to simply reduce costs in one program will raise them in others. There has to be a comprehensive view and a recognition that Medicaid, even though it pays much lower rates than other payers, pays them in the marketplace, and as those rates go up so must Medicaid's.

Mr. WAXMAN. In your testimony, you cite a Kaiser Family Foundation study that found, among other things, that nearly one-fifth of poor adults with Medicaid cards were turned away by physicians or hospitals. Why are Medicaid beneficiaries being turned away? Is it because they are poor? Do providers not want the hassle of dealing with Medicaid paperwork? Or it is because reimbursement levels are inadequate? Is the Medicaid program, despite its high and growing demands on Federal and State budgets, actually underfinanced?

Ms. RILEY. I think the reason people are turned away is a combination of all of your examples. Certainly we know that only about 34 percent of physicians participate in the Medicaid program totally. The remainder either don't participate or limit their practices.

We know that Medicaid pays lower rates than other payers. We know that the hassle of paperwork and on and off eligibility, which makes it very difficult to figure when somebody has got a Medicaid card and when they don't, all compound to make it difficult for providers.

We also know that Medicaid recipients report themselves as sicker and more disabled than their peers who are insured otherwise. This may lead to some practice discrimination. And, finally, I think, having been a Medicaid director, we hear over and over again from providers that they perceive Medicaid recipients to be noncompliant, and I think there still sadly exists a discrimination against this population.

Mr. WAXMAN. My last question: I ask you to draw on your past experience as a State Medicaid administrator and as one of the Nation's leading authorities on Medicaid managed care. We heard yesterday from the Clinton administration that the enhanced matching rates for high priority activities, like nursing home inspections and fraud and abuse control, have "served their purpose and there is no longer a need to motivate States to continue their efforts in these areas."

It was never my impression that the States needed motivation. I thought what they needed was resources. It is not clear to me that the States and the Federal Government are spending enough to manage this program, given its unbelievable complexity, and I am worried that, by cutting their Federal matching payments by $1.7 billion over the next 5 years, we will, as a realistic matter, be making it impossible for many of them to administer the program properly.

I am particularly concerned that as more States move aggressively into Medicaid managed care, the administration proposal would cut Federal resources for the quality assurance and management information systems that States need to monitor quality and access.

I am not asking for a Commission recommendation, which I know you are not in a position to provide, but can you share with us your personal views based on your extensive State experience?

Ms. RILEY. I think the issue we just talked about, the turning away of Medicaid recipients from hospitals and physicians' offices, is what leads States to find managed care attractive, a place for a client, a beneficiary, to have a medical home. But clearly we have only achieved about 12 percent enrollment in Medicaid managed care, and that program requires considerable administrative capacity.

I would find the administration's proposals quite worrisome, first noting that administrative costs are only 4 percent now on average, and that States very much need assistance, particularly with their Medicaid management information systems in order to do rate setting for managed care, in order to assure quality for a variety of services, and, finally, the enhanced match supports a variety of other activities beside Medicaid information systems; the data we have is not very accurate or acceptable now to many States and they would like to improve it.

But, second, those dollars are also used to hire consultants that assist Medicaid programs to provide better care. Medicaid tends to be in the front lines. The 40 percent of dollars spent on people with AIDS come from the Medicaid program; the outbreak of TB seems to land first in the Medicaid program. Medicaid needs to turn to expert medical advice and uses enhanced match to do so.

Finally, I think if you have no capacity to build better systems your incentives to do third party liability, fraud, abuse, quality assurance, will be diminished.

Mr. WAXMAN. My last—additional last question: Didn't we have an experience in the early eighties of cutting back the Federal dollars to the States with the idea that States could handle their programs with their own resources and they would make up the loss of Federal dollars on their own in order to do all the things that were required of them? And once we put that in place, did we find as a result of those cutbacks in Federal dollars that the States reacted not by adding their own resources but cutting back further on eligibility, on services, and on the administration of the program?

Ms. RILEY. I think the experience was different in different States, but, yes, we certainly did see that, and coupled now with all the cuts that have happened over the past several years in other social welfare programs, the States are simply strapped.

Mr. WAXMAN. Do you think the States are more strapped now than they were in the early 1980's?

Ms. RILEY. Oh, yes. I was a Medicaid director in the early eighties, and I have to say my peers today have a much more difficult job.

Mr. WAXMAN. Thank you.

Mr. Klug.

Mr. KLUG. I would like to get some sense from you both from your work on the Commission and your experience when you ran the program in Maine and what the Boren amendment has done to Medicaid costs in States, and if you think at this point some kinds of changes are likely or recommended.

Ms. RILEY. I would very much stress that I am not representing the Commission in responding.

The Boren amendment has had a real chilling effect on States' abilities to really grab hold of those two largest areas of spending in Medicaid—hospital and nursing home care. So worried are they that any change in reimbursement will bring about court cases and costly, long litigation that I think they have not taken the creative action that often characterizes Medicaid programs in these two areas, and, as a result of those very large expenditures States feel that their hands are tied behind their backs, there is little that they can do.

While no one objects to the notion and the intent of the Boren amendment—it is exactly a wise and good one, to provide effective cost reimbursement—it clearly is a very difficult impediment to States as they try to reform their programs.

Mr. KLUG. Do you have any sense of how it might be changed to give States more flexibility?

Ms. RILEY. I don't. I understand you have a Medicaid director representing that association, and I would feel more comfortable letting them answer that.

Mr. KLUG. Thank you.

Mr. WAXMAN. Mr. Brown.

Mr. BROWN. Thank you, Mr. Chairman.

You had said that Medicaid beneficiaries—it is a higher cost per beneficiary when they enter the system, when they first begin receiving benefits. At what point does that level off, if it does, compared to the general population?

Ms. RILEY. A higher cost when they enter?

Mr. BROWN. When Medicaid beneficiaries first begin receiving any kind of benefits, you had said in response to Chairman Waxman's question that costs are typically higher for new patients that have probably not had health care before now are getting it. Did you not say that?

Ms. RILEY. I'm not sure I did. I'm not sure that is exactly what I meant. I think there are differentials in the costs of different groups of patients within the Medicaid program. The aged and disabled have higher costs per capita largely because the primary services available to them are institutional services.

Mr. BROWN. So it is not a question of new patients that have not had health care in the past—that have not really received any health care in the past, their costs being higher simply because of that?

Ms. RILEY. Well, we certainly know from the very large expansions of pregnant women and children that they do not account for very large pieces of growth in this program, and those were largely individuals who didn't have care before.

Mr. BROWN. OK. Thank you.

Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you, Mr. Brown.

Mr. Greenwood.

Mr. GREENWOOD. I apologize, I just arrived and didn't hear all of your testimony. You described the States as strapped financially and unable to find the wherewithal to meet their Medicaid needs. I just came from 12 years in Pennsylvania's legislature, so I have a strong notion of what you mean.

I would like to ask you this question. If the States are strapped, what is the Federal Government?

Ms. RILEY. Equally strapped.

Mr. GREENWOOD. If not more so. The States, at least most of them, have balanced budget amendments and are making hard decisions as opposed to finding themselves trillions of dollars in debt.

Ms. RILEY. That is right.

Mr. GREENWOOD. Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you, Mr. Greenwood.

Ms. Riley, I very much appreciate your testimony, and I thank you for being with us.

Our next witness is Marilyn Holle, senior attorney with Protection and Advocacy, Inc., in Glendale, Calif.

Ms. Holle, I want to welcome you to our subcommittee hearing today. Your prepared statement will be in the record in full. We would like to ask you, if you would, to limit the oral presentation to 5 minutes.

STATEMENT OF MARILYN HOLLE, SENIOR ATTORNEY, PROTECTION AND ADVOCACY, INC.

Ms. HOLLE. Thank you.

I am from the California Protection and Advocacy Agency which serves persons at the more disabled or most disabled end of the spectrum, and, as a consequence, the removal of personal care is a particular interest to us. I think you are familiar with us since this committee is going to be considering the Developmental Disabilities Reauthorization Act.

I am really here to urge you not to repeal the mandatory character of the personal care provision. It is important as an alternative to nursing home care. You have an entitlement to institutional care. Personal care is the means by which that mandate is made realistic and available to people in the community. It is the way in which the Medicaid Act, in fact, implements the Americans with Disabilities Act.

Removing the mandatory character removes the standard and endorses a segregation in kinds of services. Right now, the availability of the personal care coming in as a mandatory alternative is pushing States to develop alternatives to nursing home care in a comprehensive way and is encouraging States to fashion alternatives that focus on a cost-effective social model—that is, a model which gives consumers maximum control and authority over the people who do the most personal, intimate things with them.

I know that the presence of personal care as a mandatory alternative had operated as an incentive in California to get both consumers and the administration together to fashion a system which we think emulates the ideal of a social model. Repealing the mandatory obligation is really going to have a significant spill-over effect, and I do not think it will, in fact, be cost effective. The spill-over effect will be Congress, in effect, endorsing segregation, saying it is OK to condition being institutionalized, that you have to be in an institution in order to get necessary services. It is a move backwards from the 101st Congress in enacting the Americans with Disabilities Act.

It is important also to have personal care as mandatory rather than merely just optional because many States look on personal care services as part of a continuum. You get it if you are not so much in need of institutional care, but if you get to the certain tip-over point, well, the nursing home care is where you belong. Making it mandatory means that it would be an overlapping alternative, and when you look at the cost you really need to look at the cost of not doing it, of not making it mandatory.

I would, however, urge that you consider clarifying the States' flexibility in adopting and putting in place social models, methods which are much more cost effective than the traditional medical model home health care services that are delivered through home health agencies.

It is important to have it mandatory as a means for defining a standard under which you measure State compliance. With personal care as a mandatory alternative, then you know what you are talking about when you look at the State program and say, "Is it insufficient in amount, duration, and scope to reasonably achieve the purposes?" because if one of the purposes of the program is to prevent institutionalization and provide an alternative to institutionalization, without it being mandatory you don't have that to give content to that Medicaid standard in looking at whether the State is meeting its obligation.

When you look at the costs of not providing personal care as a mandatory alternative, you need to look not just at the base costs of nursing home care, you need to look at all the additional costs to Medicaid to recipients who are in nursing facilities, you need to look at the increased hospital costs.

I mean, what happens when you can't find a nursing home bed? The person doesn't go away, the person stays in a hospital, often at hospital rates. And you need to look at ways of balancing and maybe shifting some of the expenditures now being provided through home health agencies, which for some people could be more efficiently provided through personal care.

[The prepared statement of Ms. Holle follows:]

STATEMENT OF MARILYN HOLLE, SENIOR ATTORNEY, PROTECTION & ADVOCACY, INC.

TESTIMONY OF MARILYN HOLLE, SENIOR ATTORNEY
PROTECTION & ADVOCACY, INC.

Protection & Advocacy, Inc., is a federally funded public interest advocacy organization mandated by federal law to protect and advocate the legal, service and human rights of Californians with developmental or mental disabilities. 42 USC §§ 6042(a), 10801 et seq. We believe our clients have the right to receive the Medicaid services they otherwise are entitled to receive in integrated settings, settings which are not isolating, and to receive those services in a manner which respects client autonomy, personal privacy and dignity. We believe that goal is achievable through the Medicaid Act's inclusion of personal care services to be available -- as of October of 1994 -- for everyone who the state Medicaid program would cover in long-term care.

However, among the proposals before you is the administration's recommendation to amend the Medicaid Act to remove the mandatory obligation of the state to provide personal care services for persons who would qualify for Medicaid funded long-term care. The Administration's announcement appears to be having a negative impact on consumers as states pull back on moving toward putting in place a personal care optional services pending October of 1994. More importantly, however, it will be seen as a Congressional endorsement of segregation and a move backwards from the ideals of the Americans with Disabilities Act. And an unnecessary move backwards because the projected cost of including personal care as a mandatory service -- and the cost of personal care services currently provided by states -- could be limited through

Congressional clarification of the discretion afforded states in delivering personal care through cost effective[1] program designs emphasizing client direction and control. The addition of personal care services as a mandatory alternative to Medicaid funded long term care may indeed have been a drafting error. But you cannot unring the bell.

Eliminating the Mandate to Provide Personal Care as an alternative to Nursing Home Care May be seen as a Congressional Endorsement of Segregation, as a Congressional Authorization for States to require that Medicaid Recipients be Institutionalized as a Condition of Receiving Care.

The Medicaid Act protects the right of persons with severe disabilities to receive services in a mainstream, less restrictive setting through 42 USC §§ 1396a(a)(10)(D) and 1396d(a)(7) which together impose an obligation to provide personal care services and other home health services as an alternative to Medicaid funded long term care. The same Congress -- the 101st -- that enacted the Americans with Disabilities Act (ADA)[2] in 1990 also in 1990 added personal care services.[3] Including personal Care services along with other home health care services provides reasonable access to the care people need to avoid Medicaid funded long-term care. Unlike the access through waivers, whether you qualify will not depend on your category of disability but on your functional need. You do not have to be institutionalized and lose your home or apartment as a condition of qualifying for waiver services.[4] Cost containment would not be through waiting lists without regard for severity of need, but rather through limitations related to medical necessity.[5] Mandatory personal care gives states the flexibility they need to insure cost effectiveness balanced against the right of Medicaid recipients to receive services in their home rather than a nursing home.

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[1] States are only now coming into compliance with the requirements of the Nursing Home Reform Act, 42 USC §§ 1396r et seq. Cost effective home alternatives would slow the increase in long term Medicaid costs from both an aging population and compliance with NHRA.

[2] 42 USC §§ 12101 et seq., Pub.L. 101-336 (July 26, 1990).

[3] Pub.L. 101-508, Title IV § 4721, effective October 1, 1994, adding personal care services to § 1905(a)(7) of the Social Security Act, 42 USC § 1396d(a)(7). Section 1905(a)(7) is made a mandatory alternative to Medicaid funded long term care by § 1902(a)(10)(D), 42 USC § 1396a(a)(10)(D).

[4] States may require that you be institutionalized when you apply to participate in a waiver program and to be institutionalized when you are accepted into the program to receive services to enable you to live in a home or community setting. Beckwith v. Kizer,

To remove the obligation to provide personal care as an alternative to Medicaid funded long term care is to step backwards. Amending § 1905(a)(7) to delete personal care services could be interpreted as authorizing a state to condition receipt of services on being institutionalized. A state may direct you from your own home to a nursing home as the only setting for receiving the care you need -- even if home care were cheaper. Such a position would perpetuate and further the evils identified by Congress in enacting the Americans with Disabiilities Act.[6] Such action would be inconsistent with the ADA's purpose of providing "a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities."[7] Instead of "the Federal Government play[ing] a central role in enforcing the standards established in [the

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912 F.2d 1139 (9th Cir. 1990).

[5] McMillan v. McCrimon, 807 F.Supp. 475 (C.D. Ill. 1992). This case involved a challenge to Illinois' refusal to process applications for participation in a home and community based waiver program providing home care because there was a waiting list for services. Plaintiff 31-year-old Paula Malek, who was diabetic and became spinal cord injured paraplegic as a result of the side effects fromn anti-rejection drugs for a kidney and pancreas transplant, could not find a nursing home which would accept her unless she took responsibility for the experimental drug she needed to take to stabilize her after the anti-rejection drug side effects, and without giving up continuing a rehabilitation program and continuing her relationship with treating physicians.

[6] Congress' findings are set out at 42 USC § 12101(a) and include

(2) historically, society has tended to isolate and segregate individuals with disabilities and, despite some improvements, such forms of discrimination against individuals with disabilities continue to be a serious and pervasive social problem;

(5) individuals with disabilities continually encounter various forms of discrimination, including ... overprotective rules and policies, ... segregation ...

(7) individuals with disabilities are a discrete and insular minority who have been faced with restrictions and limitations, subjected to a history of purposeful unequal treatment, and relegated to a position of political powerlessness in our society....

[7] 42 USC § 12101(b), "Purpose," subsection (1).

ADA] on behalf of individuals with disabilities,"[8] the federal government would be seen as licensing segregation.

Any affirmative action by Congress to eliminate personal care service as a mandatory alternative to Medicaid funded long-term care may operate to limit the ability of consumers to enforce meaningful access to home health care as an alternative to Medicaid funded nursing facility care. See, for instance, the weight accorded Congressional action in Traynor v. Turnage, 485 U.S. 535, 547-548, 108 S.Ct. 1372, 1381-1382, 99 L.Ed.2d 618 (1988). In that case the court held that the Veterans Administration could single out and exclude persons with alcoholism when extending the time for using the GI bill times because of a veteran's disability. The disparate treatment was held to be endorsed by Congress. Congressional action to delete personal care may create a barrier for Medicaid recipients seeking to assert rights to home health care to provide meaningful alternatives to institutional care. While Medicaid recipients would look to § 1902(a)(10)(D) and the Americans with Disabilities Act to define the "purpose" when determining whether the home health services provided are "sufficient in amount, duration and scope to reasonably achieve their purpose,"[9] deleting personal care services from § 1905(a)(7) may well shrink the purpose standard against which the State's program is measured.

Deleting the requirement that personal care services be an alternative to Medicaid funded institutional care also could be seen as overriding the regulations implementing Title II-A of the ADA, 42 USC §§ 12131-12134 which require that

> A public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities.

28 CFR § 35.130(d). The Appendix to the regulations explains that

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[8] 42 USC § 12101(b) "Purpose," subsection (2).

[9] 42 CFR § 449.230(b).

> Paragraph (d) requires that a public entity administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities. * * * Taken together, these provisions are intended to prohibit exclusion and segregation of individuals with disabilities . . . . * * * Integration is fundamental to the purposes of the Americans with Disabilities Act. Provision of segregated accommodations and services relegates persons with disabilities to second-classs status.

By amending the Medicaid Act by deleting personal care services as an alternative for Medicaid funded long-term care, the federal government would sabotage the integration principles underlying and animating the ADA.[10] Such an amendment will have an impact beyond the Medicaid program. It will be cited as authority for the proposition that it is reasonable for an entity to deliver services through segregated sites, to limit delivery of services through segregated settings even where it would be cheaper to do so in integrated, community settings.

Rather than Eliminate Personal Care Services as a Mandatory Alternative to Medicaid Long-Term Care, Congress instead should take Steps to Insure that Personal Care Services is a Cost Effective alternative by Clarifying State Flexibility in Delivering Personal Care Services through Individual Providers, Consumer Controlled and Directed, Social Model Systems.

Personal care services[11] are currently part of the Medicaid state plan in about 34 states.[12] Eighteen months ago personal care services were part of the Medicaid state plan in about 18 states.[13] Rather than eliminating personal care as a mandatory alternative to Medicaid long-term care, Congress' focus should be on continuing mandatory personal care with clarification of the flexibility afforded states in designing cost effective systems with maximum consumer control and direction, attendant care systems which follow a social model rather than a medical model approach. Congress should endorse the cost effective ways in which personal assistant services have been delivered under waiver programs as options available to States through personal care services.[14] It is important for Congress to dispell the lingering chilling effects of the withdrawn medical model and Draconian proposed regulations[15] and their predecessor HCFA Medical Assistance Manual Guidelines. Absent Congressional clarification, states -- to their and the federal government's financial detriment -- will continue to look to the proposed regulations as defining the administrative requirements for personal care services.

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[10] See, particularly, the seminal article by the late Tim Cook, "The Americans with Disabilities Act: The Move to Integration, " 64 TEMPLE L.REV. 393 (1991).

[11] The regulations for personal care services are at 42 CFR § 440.170(f) authorizes services in a Medicaid beneficiary's home prescribed by a physician in accord with a treatment plan and provided by a qualified individual who is supervised by a registered nurse and who is not a member of the recipient's family.

[12] THE CCH MEDICARE & MEDICAID GUIDE at ¶ 15,500 (3-11-93) indicates that there are 9 states which include personal care services in its state plan for categorically needy (mandatorily covered) (AL, AK, DE, ID, MO, NV, OR, SD, WA), and that there are 23

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states which include both categorically needy and medically needy (optionally covered) Medicaid recipients (AR, CA, DC, FL, KS, ME, MD, MH, MI, MN, MT, NE, NH, NJ, NY, NC, OK, PA, RI, TX, UT, WV, WI). Though the chart indicates California's State plan covers both mandatory and optional Medicaid recipients, in fact California covers only those Medicaid recipients California is required to cover.

[13] CCH MEDICARE & MEDICAID GUIDE ¶ 15,500 (October of 1991), cited in Fatoullah, "Medicaid Home Care for the Elderly and Persons with Disabilities," 28 CLEARINGHOUSE REVIEW 882, 888 n. 41, 895-896 (December 1992). However the listing erroneously excluded Texas which has included personal care services in its State Medicaid plan since 1979. Kennedy & Litvak, "Case Studies of Six State Personal Assistance Service Programs Funded by the Medicaid Personal Care Option," Research and Training Center for Public Policy on Independent Living at the World Institute on Disability (Oakland CA September 1991).

[14] See, also, research and state surveys by the Research and Training Center on Public Policy and Independent Living at the World Institute on Disability, 510 Sixteenth Street, Suite 100, Oailand CA 94612, voice/TDD (510) 763-4100, fax (510) 763-4109, which analyzies personal care optional programs including the extent of consumer control in selecting, terminating and directing the delivery of authorized services.

[15] 53 Fed.Reg. 24103 (June 27, 1988), as reported at New Dev. ¶ 37,154, CCH MEDICARE & MEDICAID GUIDE.

California's experience in moving from a Title XX and state funded attendant care program (In-Home Supportive Services or IHSS) to one funded in part through Medicaid personal care illustrates the long-term effect of the restrictive Medical Assistance Manual and withdrawn proposed regulations. California consumers -- since 1979 when Medicaid funding of attendant care was first raised -- have opposed covering personal assistance services under Medicaid. Consumers feared a loss of autonomy and control by not being able to continue relying on individual providers[16] as the primary means for delivery of services, by a constriction in the range of people who could continue to be served in their home,[17] by interference in the relationship with treating sources by the character of the supervision which would be required, and a concern about restrictions on family members as providers since the most severely disabled often are cared for by family members who have given up work to do so. Research by the World Institute on Disability identified and analyzed personal care delivery systems, such as those in Michigan, Minnesota and Oregon, whose programs included elements of a social model Medicaid personal care delivery system, plus the withdrawal of the proposed federal personal care regulations, plus a California budget crisis enabled our State administration and consumers to work together to reach a detailed consensus on the state plan amendment adding personal care services. Consumers were animated by a desire to insure their privacy and dignity interests would be protected by retaining their authority to select and fire qualified providers and by being able to control and direct how the most intimate and personal of services would be delivered to them in their homes. For the State the mandatory personal care provision in § 1905(a)(7) operated as an incentive to working with consumers.[18] The sense of consumers was that the State believed that if a state plan amendment adding personal care services were approved now, California's personal care program would be grandfathered even if more costly features were added in regulations implementing the mandatory personal care provision in § 1905(a)(7).

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[16] In most Counties consumers are able to select and direct their own provider in his or her delivery of services authorized as necessary by the County welfare department. In most cases the provider is paid directly by the EDS computer though in some high hour self directing cases the consumer receives funds in advance each month in order to pay the providers.

[17] The state program includes persons who only needed asssistance with shopping and domestic services to quadriplegic individuals vulnerable to unpredictable autonomic dysreflexia attacks to postpolio ventilator dependent alumni of Rancho Los Amigos.

[18] Consumers believe that the announcement by the Administration of its intention to seek repeal of the provision making personal care services a mandatory alternative to Medicaid long-term care contributed to the California State administration early to mid

Waivers are no Substitute for Personal Care as a Mandatory Alternative for Persons who would Qualify for Medicaid Funded Long-Term Care.

The availability of personal care services as a mandatory alterantive to Medicaid long term care would reduce the need to rely on waivers -- and would reduce the extra costs involved in getting a waiver approved and renewed every three to five years and the extra administrative time in managing the waiver. Waivers would continue to be important as a means to provide innovative and flexible service packages,[19] as a means of providing more intensive services to targetted populations,[20]s a means to enable the nondisabled spouse to obtain the benefits of the spousal impoverishment rules which otherwise would not kick in unless the disabled spouse were institutionalized,[21] and waiving of community deeming rules.

But because waivers are necessarily piecemeal, and -- with the exception of waivers under 42 USC § 1396n(d) for seniors -- conditioned on arcanely complicated cost limitation and "cold bed" rules,[22] they provide only a limited alternative to long-term care. Similarly, programs funded under Title III Older Americans or Title XX have

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March to halt implementation of the state plan amendment to add personal care as an optional service. The State Administration is going forward with implementation on April 1, 1993.

[19] For instance, the inclusion of adult day programs and support services to family members under the "frail elderly" program, "Home and Community Care for Functionally Disabled Elderly Individuals" at 42 USC § 1396t.

[20] For instance, waivers for infants and children HIV positive or drug exposed at birth. 42 USC § 1396n(e).

[21] 42 USC § 1396r-5.

[22] See, for instance, the complicated ceilings and cost formulas in 42 USC § 13696t(e).

tended to be local and limited.[23] And usually such programs meet the needs of those marginally eligible for Medicaid funded long-term care but not for severely disabled persons. They do not create an entitlement in the community for persons for persons who are given an entitlement to services in a nursing facility. Personal care as a mandatory alternative to Medicaid long term care is now necessary for compliance with the spirit of the Americans with Disabilities Act.

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[23] Litvak & Kennedy, "The Medicaid Personal Care Services Optional Care Benefit: Policy Issues," Appendix B, re-examination of 1985 survey data on 157 attendant service programs. The Research and Training Center on Public Policy and Independent Living at the World Institute on Disability (Oakland CA September 1991).

Mr. WAXMAN. Thank you very much, Ms. Holle.

Let me start off with some questions. First of all, yesterday the administration argued that repeal of the personal care services mandate was justified because—and I quote—"it would give States necessary flexibility in how they structure their long-term care program." What, in your view, will this flexibility mean in the real world for people with disabilities who are at risk of nursing home care?

Ms. HOLLE. In the real world, that flexibility means that nursing home wins and consumers lose because there is no way in which a consumer can say, "I'm entitled to services in an institution, I am also entitled to services in the community, and at a reasonable level to provide an alternative to that nursing home care." I think, frankly, the States' flexibility is limited by the Americans with Disabilities Act, and I think giving the States flexibility to ignore that would be both damaging and hurtful to consumers and to how the Americans with Disabilities Act is going to be interpreted elsewhere.

Mr. WAXMAN. Could you review for me the current situation in California and the impact the administration's proposal will have on access to personal care services for the low-income elderly and disabled in our State.

Ms. HOLLE. The presence of that October 1994 clock had operated as an incentive on the State to work with consumers in developing a cost-effective social model for accessing personal care, essentially transferring about two-thirds of the current 178,000 persons who receive attendant care under our title XX program.

The Clinton administration's announcement that it was seeking repeal caused a significant disruption. I hope we are back on track in trying to negotiate the implementation of the State plan amendment, adding personal care, and I hope and will know today—will know maybe later today—whether it all worked out.

But the real problem down the line is going to be the lack of a standard and the sort of concept of, when you impose limitations, to what extent do you have to consider the impact at the most severely disabled end of the spectrum, the people we represent in terms of providing meaningful alternatives to institutional care. Without that mandatory element, there is no ammunition for consumers to say it is not reasonable, it doesn't provide a reasonable alternative, and my consumers are at the severe end.

Mr. WAXMAN. I know that I, for one, am very uncomfortable with the prospect of taking away the certainty of coverage which will allow disabled people to remain out of institutions, and I suspect other members are as well. The problem, of course, is that we are required to reduce Federal Medicaid spending by $7.8 billion over the next 5 years, and the CBO estimates that repealing the personal care services requirement will save $4.2 billion. Do you have any other suggestions as to other ways to reduce Federal Medicaid spending by $4.2 billion?

Ms. HOLLE. Yes. I think looking at long-term care as a collective. One of the problems in why personal care, where it has been used, has been more expensive than it should be is States' chariness about what they have to have in place: To what extent do they have to conform to a medical model?

One way of dealing with some of the costs is for Congress to emphasize State flexibility in providing personal care through social model systems so as to reduce the cost not only for personal care, which I think in part because of the 1994 clock is now up to 48 States, and within the past 18 months there has been an explosion, but it would reduce personal care costs in existing programs, it could pick up appropriately some people who are now served through home health care and more expensive modes, and I think people really don't realize the extent to which nursing home costs are going to increase now that finally the Nursing Home Reform Act is being enforced.

Mr. WAXMAN. What do you mean by social models as opposed to the medical model for long-term care?

Ms. HOLLE. I think a social model is one typified by California's experience with its in-home supportive system where the consumer selects who will bathe him and perform all these personal tasks, where there is a system for direct payment from the State to the provider in accord with hours authorized by the State through the county, where you try to minimize the extent of overhead and, instead, if you need situations where there needs some case management, you look at it by accessing case management for those individuals. Personal care with an emphasis on State flexibility in how it is delivered would achieve that goal.

Mr. WAXMAN. Thank you.

Mr. Klug.

Mr. KLUG. It was 6 or 7 months ago that the Bush administration rejected Oregon's request for a Medicaid waiver, and the Bush administration's objections were largely based on concerns with the Americans with Disabilities Act and the implications of the Oregon plan. The Clinton administration, obviously, in the last several weeks has now decided to give Oregon its waiver to let them try their experiment. Any comments on your concerns about ADA and whether that waiver should have been given or not given?

Ms. HOLLE. I don't know all the details, but as an organization that represents people at the most severely disabled end, we always have concerns about whether we are in the group that is going to be lopped off.

I frankly don't know what the redrafted plan has in it to address the concerns raised previously that formed the basis for the rejection. I agreed with the rejection because of its impact on the most severely disabled.

Mr. WAXMAN. Thank you, Mr. Klug.

Mr. Brown.

Mr. BROWN. No questions.

Mr. WAXMAN. Mr. Kreidler, do you have questions?

Mr. KREIDLER. No questions.

Mr. WAXMAN. Mr. Greenwood.

Mr. GREENWOOD. If I understand the large part of your argument here today, it is that if you eliminate the mandate for personal care to the States that significant numbers of clients will end up in more restrictive, more expensive nursing homes than in personal care facilities. Is that correct?

Ms. HOLLE. Yes.

Mr. GREENWOOD. It seems to me that there are two potential clients for these personal care boarding homes. One is that client who really doesn't need nursing home care. The other is the client who wasn't going to get nursing care anyway, but moved up the scale into a personal care facility and, under the existing mandate, is covered. Is that right?

Ms. HOLLE. No. What we are talking about is no facility. Personal care is a system of attendants going into your home at specific times to assist you with the personal care tasks that you can't——

Mr. GREENWOOD. So personal care boarding homes are not covered under this scenario?

Ms. HOLLE. No, no. This is a service——

Mr. GREENWOOD. It is home health care.

Ms. HOLLE. It is home health care, but not really. It is generally client directed, but somebody going into the home to help the person with tasks he or she cannot perform. It is services to enable you to stay in your home, to stay with your family.

Mr. GREENWOOD. Thank you for that clarification.

My question is, without the mandate, wouldn't it be reasonable to assume that the States would ordinarily seek the cost savings that are available to avoid the nursing care costs?

Ms. HOLLE. If this were a rational system, perhaps that would be the case. It doesn't seem to happen, in part because of not necessarily bad notions. There is a lot of kind of left-over paternalism that people at the more severely disabled end of the spectrum are safer in a nursing facility setting.

I think part of what the ADA is, is to provide an engine for change that helps us relook at some of those assumptions, and personal care, making that mandatory, provides the incentive and protection for individuals who would rather have services in their home as opposed to going into a facility. Who I am concerned about are people at the severely disabled end who States often say should be in an institution, and that is our decision.

Mr. GREENWOOD. Given the fact, as the chairman stated, that we have to find savings, would a middle ground be available? What if we don't require the States to provide personal care, but we do require them to screen all potential clients for nursing homes to see if there is at least a less restrictive alternative for them? Would that be a middle ground? I am not asking you to support that, but would it be a middle ground?

Ms. HOLLE. I don't think so because the criteria—I mean once you screen, there are a lot of States that have screening, and you end up in the nursing facility because there is not an alternative. What making personal care mandatory does is create those alternatives so that there is, in fact, a less restrictive way to go, and it really puts some emphasis on the right of individuals who are the most severely disabled to have alternatives other than nursing facilities, and cheaper alternatives.

Mr. GREENWOOD. Is there any reason for us to believe that there are clients receiving personal care at home who could, in fact, do without it?

Ms. HOLLE. I can really speak only to California's experience, and California's experience is that the assessment process is pretty stringent and the services are limited. You don't receive authorization for hours unless the task is something which you cannot do or cannot do without injury to yourself.

I could imagine that there would be instances where some of the services could be done at risk of injury to the individuals, but I think it is perfectly possible and usual to design an assessment authorization system which only authorizes those things which are truly needed.

Mr. GREENWOOD. Thank you.

Mr. WAXMAN. Thank you very much, Mr. Greenwood.

Ms. Holle, I very much appreciate your being with us. Thank you for being here today.

Ms. HOLLE. Thank you.

Mr. WAXMAN. Our next panel will address the administration's proposal to reduce Federal matching payments for certain high-priority administrative functions, including fraud and abuse control, nursing home inspections, and management information systems. CBO estimates that this proposal will reduce Federal Medicaid spending by $1.7 billion over the next 5 years.

Dr. David Smith is the commissioner of health for the State of Texas. Edward J. Kuriansky is the director of the Office of Special Prosecutor for Medicaid Fraud Control in New York. Barbara Frank is associate director of the National Citizens' Coalition for Nursing Home Reform.

I would like to thank you all for being here. Your prepared statements will be in the record in full. We would like to ask you to limit the oral presentation to 5 minutes.

Dr. Smith, why don't we start with you.

STATEMENTS OF DAVID R. SMITH, COMMISSIONER, TEXAS DEPARTMENT OF HEALTH; EDWARD J. KURIANSKY, SPECIAL PROSECUTOR, NEW YORK STATE MEDICAID FRAUD CONTROL; AND BARBARA FRANK, ASSOCIATE DIRECTOR, NATIONAL CITIZENS' COALITION FOR NURSING HOME REFORM

Mr. SMITH. Thank you, Mr. Chairman, members of the subcommittee.

I am David Smith, commissioner of health for the Texas Department of Health and also a pediatrician. I appreciate the opportunity to talk to you today about the proposed reduction in matching rate for administration in the Medicaid program.

I am really here today because I hope the administration's proposal to reduce administrative matching rates actually can be rethought and looked at and perhaps altered, that we can all work together for a more viable solution. I am going to try to make about four or five points as I go through my testimony.

Most importantly though, I think we have to be cognizant of the terms "cost effectiveness" and "cost containment" and who may be most vulnerable to these kinds of proposals, and I think some of those have been touched upon by Ms. Riley, but I am going to reinforce some of those from our State's perspective and what I think we need to be doing in these areas.

By the way, I would like to thank Chairman Waxman and Representative John Bryant for addressing this issue before the Budget Committee a few weeks ago.

My concern is that the proposal before you is an example of what I would call toll road economics: sometimes you pay when you get on, sometimes you pay in the middle, and sometimes you pay when you get off. Changing the location of the toll booth, though, really doesn't make much difference as far as the amount, and it certainly doesn't reduce the toll overall.

This proposal I don't believe actually will reduce cost. I think it will shift it, and I am also concerned about some of the quality measures that have already been mentioned, that we may actually lose some of our ability to effect some quality in some areas such as long-term care and investigations and also, as was mentioned by Ms. Riley, for us to provide some technical assistance and hand holding in certain areas such as managed care. These things will be reduced, I think, through this kind of approach.

Because many of the administrative responsibilities that are in place and placed upon States are federally mandated, proposals such as this one are another round of passing the burden, again without passing some bucks that are necessary. We cannot pull ourselves up by our own bootstraps—which is something we often talk about in Texas, unfortunately sometimes too often—if the Federal Government is standing on our toes, and I think we have to be cognizant of that.

It is popular and it is easy to say we need to trim the fat, and I think this is something that we often talk about in government—we are certainly looking at it in our State—but when you look overall—and I think again this was mentioned—we are talking about, in our State, a reduction of administrative costs for Medicaid over the last 2 years from about 5.1 percent down to about 3.6 percent or so. Here is not the area where we are going to see the best movement for cost-effective efficiency or cost containment. The other 97 percent of the budget really is where the fat and where the potential for savings are; it is not in this area.

Somehow in our deliberations and the deliberative dictionary that we use, we have managed to automatically equate administrative with wasteful, with unnecessary, but I submit that administrative costs in government are the equivalent of cost of doing business in the private sector. Someone has to turn on the lights to the store before you can provide goods and services to your customers. We can save money by laying a person off or turning the lights off, but I don't think our customers are going to be particularly happy about that.

Some of the areas in Medicaid over the last several years as we have used administrative dollars have actually been put in place to try to make this a more friendly environment to get services, to get people eligible and make sure they can get through a maze of systems and programs. Those kinds of things are also at risk in these kinds of decisions.

We can take no pride in our decisions to cut costs if those decisions deny our citizens the proper health care. This is really the second point to be made besides the fact that this is a small percentage of the overall budget. Where do these dollars come from when States lose them? We are going to have to make a decision here as you reduce match in certain areas.

If we decide that we are going to protect quality, protect the rights of citizens to good care, whether it is long-term care or others, the money is going to have to go somewhere if you are going to have protection. In our case, those dollars will come from services, and I want to make that very clear. Our budget is in a ditch too in the State of Texas, and we have got to make some tough decisions, and I will actually tell you where those dollars will come from, I believe, in services and how many people will be affected.

We are estimating that this type of proposed reduction in administrative rates may result in a loss of almost $76 million to the State of Texas. I argue that we are not actually a rich State, we are actually quite poor. As most of you know, I think on per capita income we are about 33rd on the list, and that is only because we have Ross Perots at the upper end that pull our per capita income up.

But the point is that at $76 million, that would mean that we would lose the dollars we have now that currently allow us to go to 185 percent coverage for pregnant women and children. That is about $25 million. If you look at our Ribicoff option and for medical needy, if you add those two together, those would also be lost as options in our State, and our State legislature is already looking at those kinds of things now because they don't think we can do all the options we have been picking up, so something will give.

What does that mean for Texas in terms of real people? That is somewhere between 45,000 and 50,000 individuals that would be lost services, or, in fact, we forget our regulatory functions. I can't do that either because in the area of long-term care many of you may have seen the 20/20 special on our nursing homes, and as a new commissioner of health one of our priorities is to put in place some more effective regulatory standards and quality of care measures for that industry. We can't lose that initiative, and this would take it away.

[The prepared statement of Mr. Smith follows:]

STATEMENT OF DAVID R. SMITH, COMMISSIONER OF HEALTH, TEXAS DEPARTMENT OF HEALTH

Chairman Henry Waxman and members of the Subcommittee on Health and the Environment, my name is David Smith and I am Commissioner of Health for the Texas Department of Health in Texas. I truly appreciate the opportunity to come before you to talk about the administration's stimulus and deficit reductions packages, particularly with respect to the proposed reductions in Medicaid administrative matching rates. However, my testimony would not be complete without first underscoring the fact that, with the exception of this particular provision, President Clinton's stimulus and investment proposals are heartening for those of us in health and human services in Texas.

Texas estimates the stimulus package will bring 30,000 jobs and $500 million to the Lone Star State. I would highlight the President's initiative to increase spending on immunizations by $300 million for if we cannot fix measles then there is little we can do. According to the Children's Defense Fund, Texas ranks last in the percentage of children immunized so this initiative is clearly of great importance to the lives of our State's youth. Consequently, Governor Ann Richards, among others, is on record as supporting this package.

I also come here today in hope that the administration's proposal to reduce administrative matching rates can be improved upon to provide us with the opportunity to work together to achieve joint savings in the Medicaid program without affecting beneficiaries. I would like to thank Chairman Waxman and Texas Congressman John Bryant for their work in addressing this issue and their concerns before the Budget Committee just a few weeks ago.

Unfortunately, as presently constructed, Texas estimates the proposal to level the Medicaid administrative match rate at 50 percent will cost us $27.6 million on an annualized basis and that it will reduce the quantity and quality of services to beneficiaries.

In the face of such a shortfall, the Texas Medicaid program will be faced with three choices:

—Absorb the reduction by scaling back service delivery improvements.

—Shifting funds planned for client services to maintain the level of administrative expenditures.

—Raise taxes, although that would only be a cost shift to States and is unlikely in Texas.

In either case, the outcome will result in less effective delivery of services. If Texas were to adopt the latter approach the loss of funding for services would be far greater than $27.6 million. When you reallocate funds from services, there is a multiplier effect due to a corresponding loss of Federal matching funds. This is precisely the type of drastic cuts and cost shifting that occurred when Omnibus Budget Reconciliation Act of 1981 provisions were enforced in 1982–84 and they can be expected again.

Texas and most other States will likely take an approach that combines both options. With respect to administrative cuts, these will be difficult in Texas due to the fact that Texas's Medicaid administrative expenditures have steadily declined as a percentage of overall program expenditure from 5.29 percent in fiscal year 1991 to 3.15 percent in fiscal year 1994.

Cutting the administrative match for fraud and abuse activities from 75 percent to 50 percent, for example, would result in a 50 percent reduction in fraud and abuse investigations. In fiscal year 1992, the Legislature appropriated nearly $500,000 which was matched with almost $1.5 million in Federal funds. If the Federal match drops to 50 percent, the Texas Medicaid fraud control program will be cut from $2 million to $1 million, a rather substantial cut that will seriously hinder fraud and abuse activities and send the wrong message to unscrupulous providers. In addition, the Texas Attorney General's employs 21 investigators covering 254 counties and their caseload has expanded rapidly in recent years along with the Medicaid program's caseload. It is important that we at least maintain our current level of services.

Texas estimates a loss of $10.3 million in administrative matching funds for survey and certification of nursing homes and ICF-MR's annually. A cut from $21.7 million to $11.4 million, or 47 percent, would undoubtedly reduce the quality of this operation and result in the elimination of many policy and training personnel, pharmacists, nutritionists, social workers and public health technicians. The loss of such personnel will prohibit timely surveys, follow-up visits and complaint investigations. I do not believe this is the result that this Congress or the administration is attempting to achieve. Reducing the funding ratio for administrative costs should include a corresponding reduction in survey and certification requirements. Instead, we need to work together on formulating an alternative.

In the context of the larger and growing debate around health care and welfare reform, I am deeply concerned about the long-range implications of these cuts. For instance, if the President, Congress and States jointly adopt a managed competition model for health care delivery, States will need to completely overhaul their data systems and greatly enhance data collection efforts in terms of quality, access to providers and costs. New system development costs in both health and welfare will be overly burdensome to States and proposals to cut administrative matching rates at this time seem to be in conflict with all that is being considered in the not too distant future.

Rather than continuing to argue about relative matching rates and cost shifting between States and the Federal Government, we should take the opportunity of having a new administration and a new Congress to refashion the Federal-State partnership.

In short, we both have the same taxpayers and beneficiaries. Rather than pursuing a policy of reducing administrative matching rates that do nothing more than cost shift to States, which is a zero-sum gain for taxpayers, the Federal Government and the States should work together to achieve real savings through the improvement and/or elimination of ineffectual programs without harming beneficiaries. Within the 3 percent spent in administrative costs in Texas, there may very well be savings that can be achieved jointly without disastrous and arbitrary policy implications. Instead of discussing costs, we should be talking about people and services. We should be reinforcing cost savings by putting funds in the "front-end"—in prevention. We should pay for pap smears and not hysterotomies; immunizations and not the hospitalization of unnecessarily sick children.

I am also certain we can also achieve some cost savings within the other 97 percent of Medicaid or other programs without harming beneficiaries. Governor Richards and 40 other Governors submitted over 350 pages of proposals to President Clinton on administrative and regulatory changes that they individually recommended to improve the program. We need to encourage HCFA to immediately review, consider and implement the many suggestions made by States. Many of these proposals would result in cost savings to both the States and Federal Government and should be considered by the administration and the Congress as real deficit reduction measures rather than the cost shifting that will result from this proposal to reduce administrative matching rates for Medicaid, AFDC and Food Stamps.

Again, while I am here to express the State's concern about this proposal, Texas leadership has expressed overall support for the entire package and we all stand ready to assist and participate with the administration and Congress in continued discussions about the future of our Nation's health and welfare systems.

Mr. WAXMAN. Thank you very much, Dr. Smith.

Mr. Kuriansky.

STATEMENT OF EDWARD J. KURIANSKY

Mr. KURIANSKY. Mr. Chairman, members of the committee, as director of the New York Special Prosecutor's Office and past president of the National Association of Medicaid Fraud Control Units, I am very pleased to appear before you today to discuss the subject of Medicaid fraud and the devastating impact the administration's proposal to reduce the Federal match from 75 to 50 percent would have on this Nation's 41 State Medicaid fraud control units.

Simply put, the proposal would gravely threaten the viability of the fraud control units and would surely result in these superb law enforcement offices sharply curtailing their investigative activity. Astonishingly at this time of economic and health care crisis, when the express goals of the administration are to maximize revenues, reduce spending, and contain health care costs, this proposal would effectively undermine all three objectives. In fiscal and policy terms, it is utterly unsound.

It is a special privilege, Mr. Chairman, to appear before this committee, which was so instrumental in passing the landmark Federal legislation that established and funded the fraud control program 15 years ago. Since the inception of this pioneering program, the 41 certified State units have successfully prosecuted over 6,000 corrupt medical providers and identified, recovered, and deterred the theft of billions of program dollars. In fact, the majority of health care fraud convictions, penalties, and exclusions reported yearly by the HHS Office of Inspector General are based upon unit prosecutions. In a very real sense, the Medicaid Fraud Control Program now fills a pivotal role in the surveillance and enforcement of this Nation's health care industry much as the IRS and SEC have long served as an integrity check on our taxing and securities system.

While the units' success in prosecuting Medicaid provider fraud is widely known, it is perhaps less well known that the units are the only law enforcement agencies in the country specifically charged with investigating patient abuse and neglect. Congress passed Public Law 95-142 in 1977 not only because of evidence of massive chicanery in the Medicaid program but also because of horrendous tales of nursing home patient abuse and resident victimization.

Mr. Chairman, the importance of controlling fraud, waste, and abuse in the health care industry cannot be overstated. GAO recently estimated that fraud accounts for 10 percent of this Nation's $800 billion in total health care costs, and in the Medicaid program where sizable cash rewards continue to attract predatory and extremely cunning providers, we are certainly talking about many hundreds of millions of stolen taxpayer dollars.

During the past decade, we in New York have literally seen a feeding frenzy on the Medicaid program, a period of unprecedented white-collar wilding in which wave after wave of multi-million-dollar fraud have swept through nursing homes and hospitals, to clinics and pharmacies, podiatry and durable medical equipment, radiology and labs, and, more recently, home health care. Each surge has brought its own special brand of profiteer in search of the next great loophole in the Medicaid system. While Medicaid fraud is certainly no stranger to New Yorkers, it is also, as my written text details, a pervasive and well documented problem throughout the United States.

But even more important than any specific prosecution or recovery is the fact that the units have demonstrably deterred the loss of many more millions of dollars in Medicaid overpayments. We have often witnessed a pattern of sky-rocketing Medicaid expenditures followed by a sudden, sharp dollar decline in the wake of a unit investigation of a particular provider group, and that too I have detailed in my written remarks.

In the area of patient abuse, years of investigation have made it clear that neglect, mistreatment, and economic exploitation of nursing home residents is a problem of far greater magnitude than previously thought. Not only have the units prosecuted hundreds of nurses and aides and orderlies for raping, sodomizing, beating, kicking, and force-feeding their helpless patients, but we have uncovered even more egregious cases of corporate and management neglect.

Increasingly over the years, the State fraud units have come to be viewed as the leaders in the detection of fraud and abuse in the health care industry. Indeed, just last summer the National Association of Attorneys General urged Congress to include fraud control as a significant priority in any new health care form legislation and cited the fraud units as the model to be followed.

As you know, the units are currently funded on a 75 percent/25 percent basis. In practical terms, the administration's proposed reduction would require a State to double its contribution from 25 to 50 percent just to maintain its unit at present strength. Coming at a time when cash-poor States are already unable to fund their units, let alone many other essential programs, this proposal would surely result in most units being dissolved or drastically downsized.

As far back as 1980, GAO studied this very issue and concluded that without continued 75 percent funding many fraud units would probably cease to exist or operate at a reduced level of effectiveness.

In closing, Mr. Chairman, let me just say that if slowing the growth of health care expenditures due to fraud and abuse is to remain, as it must, a serious objective of government, then gutting this remarkable program would be a tragic miscalculation.

[Testimony resumes on p. 309.]

[The prepared statement of Mr. Kuriansky follows:]

Statement of Edward J. Kuriansky, Special Prosecutor, Office of the New York Special Prosecutor for Medicaid Fraud Control

TESTIMONY OF

EDWARD J. KURIANSKY
SPECIAL PROSECUTOR

OFFICE OF THE NEW YORK SPECIAL PROSECUTOR FOR MEDICAID FRAUD CONTROL

Mr. Chairman, Members of the Committee:

As Director of the New York Special Prosecutor's Office and past president of the National Association of Medicaid Fraud Control Units, I am very pleased to appear before you today to discuss the subject of Medicaid fraud and abuse and the devastating impact the Administration's pending proposal to reduce the federal matching rate from 75% to 50% would have on this nation's 41 state Medicaid Fraud Control Units (MFCUs).

Simply put, this proposal would gravely threaten the viability of the fraud control units and would most assuredly result in these superb law enforcement offices having to sharply curtail their investigative activity. Astonishingly, at this time of economic and health care crisis, when the expressed goals of the Administration are to maximize revenues, reduce spending, and contain health care costs, this proposal would effectively undermine all three objectives. In both fiscal and policy terms, it is, perhaps unwittingly but nevertheless utterly, unsound.

Mr. Chairman, it is a special privilege to appear before this Committee which was so instrumental in passing the landmark federal legislation that established and funded the national Medicaid Fraud Control Unit program some 15 years ago.

Medicaid Fraud Control Units are federally funded, state law enforcement entities which investigate and prosecute provider fraud and misconduct in the administration of the Medicaid program. In addition, and perhaps even more important, the Units aggressively pursue complaints of patient abuse and neglect of the elderly in nursing homes and other Medicaid - funded health care facilities. The Units, which operate totally separate and apart from the single state administrative agency and are usually located in the state Attorney General's office, are staffed by professional teams of attorneys, investigators, and auditors specially trained in the complex litigation of health care fraud.

Since the inception of this pioneering program, the 41 federally certified state Units (see attached list) have successfully prosecuted over 6,000 corrupt medical providers, vendors, and elder abusers -- convictions that would surely not have occurred without this vital piece of legislation -- and have also identified, recovered, and deterred the theft of billions of program dollars. In fact, the majority of health care fraud convictions, penalties, and exclusions reported yearly by the HHS Office of Inspector General are based upon MFCU prosecutions. In a very real sense, the Medicaid Fraud Control Unit program now fills a pivotal role in the surveillance and enforcement of this nation's health care industry, much as the IRS and SEC have long served as an integrity check on our taxing and securities systems.

While the Units' stunning success in prosecuting Medicaid provider fraud is widely recognized, it is perhaps less well known that the Units are the only law enforcement agencies in the country specifically charged with investigating patient abuse and neglect. Congress passed P.L.95-142, the Medicare-Medicaid Anti-Fraud and Abuse Amendments of 1977, not only because of the evidence of massive fraud and chicanery in the Medicaid program, but also because of the horrendous tales of nursing home patient abuse and resident victimization -- and the Units are justly proud of their record in protecting the frail and vulnerable institutionalized elderly.

The importance of controlling fraud, waste, and abuse in the health care industry cannot be overstated. The General Accounting Office (GAO) recently estimated that fraud and abuse accounts for 10% of this nation's $800 billion in total health care costs, and while there may be no way to put a precise figure on it, we are certainly talking about many hundreds of millions of stolen dollars in the Medicaid program alone.

During the past decade, in particular, we have literally seen a feeding frenzy on the Medicaid program, a period of unprecedented white collar "wilding" in which wave after wave of multimillion dollar fraud has swept through nursing homes and hospitals, to clinics and pharmacies, podiatry and durable medical equipment (DME), radiology and labs, and, more recently, home health care. Each surge has brought its own special brand of profiteer in search of the next great loophole in the Medicaid system.

Perhaps our most pressing concern in New York today is a recent phenomenon known as "playing doctor" that involves a vast network of Medicaid physicians, pharmacists, and recipients engaged in the blatant dealing of drugs and 'scrips for cash on the black market. Unlike many earlier frauds, this one is as much driven by recipients and their desire for drugs as it is by predatory providers. For these abusive recipients, a Medicaid card has become their American Express gold card -- and on the street they say, only half-jokingly, "Don't leave home without it."

In this illicit underground economy, recipients -- often drug addicts -- "burn" their card (which means quickly running up $20,000 - $30,000 in Medicaid charges) by visiting unscrupulous doctors and obtaining utterly unnecessary prescriptions for a laundry list of expensive medications. The physicians operate out of seedy storefront offices that resemble fortified prison cells, and they occasionally examine -- or rather question -- their so-called "patients" via telephone through windowed wall partitions. In some instances, the doctor's receptionist or security guard will even tell the 20 - 30 patients crowded in the waiting room what they should say is ailing them and what drugs the doctor is willing to write a 'scrip' for that day.

These physicians are in business for the sole and exclusive purpose of exploiting the Medicaid program and have no interest whatsoever in delivering real medical care to real Medicaid patients. As for the recipients, they either sell their 'scrips outright for cash to accommodating druggists or have the prescriptions filled and peddle their goods to street buyers who, in turn, recycle them to drug diverters or other pharmacies.

As we speak, the "playing doctor" scam is plaguing ghetto communities throughout New York City and probably costing taxpayers somewhere between $75 - $150 million a year.

However, while Medicaid fraud is certainly no stranger to New Yorkers, it is also a pervasive and well-documented problem throughout the United States. For example:

◆ In California, disreputable providers of incontinence supplies obtained eligibility information from Medi-Cal beneficiaries and billed the program hundreds of million of dollars for beneficiaries who were not incontinent or for supplies that were never ordered or delivered.

◆ The Wisconsin MFCU uncovered an extensive pattern of fraud involving dozens of firms in the medical transportation industry. Typical scams included: padded mileage; billing for phantom second attendants; charging for trips either not provided or not prescribed; forging physicians' prescriptions; and paying kickbacks to riders.

◆ In Massachusetts, the Medicaid Fraud Control Unit recently achieved the largest civil recovery in its 14-year history when a Boston hospital and rehabilitation center agreed to an unprecedented $12 million settlement.

- A Virginia pharmacist, who pleaded guilty to 6 felony counts of Medicaid fraud and grand larceny from Blue Cross/Blue Shield, was sentenced to 90 years in the state penitentiary. The 90-year sentence was suspended on condition that he serve 12 months in jail, make restitution of $270,000, surrender his pharmacy license, and agree to withdraw as a Medicaid provider for life. The pharmacist had billed for expensive medications that were not prescribed by a physician and not received by patients. This ripoff, the defendant said, was "just too easy" and all he had to do was "push a few keys on his computer."
- In Tennessee, a Nashville radiologist pleaded guilty to obtaining money under false pretenses and was ordered to pay $210,000 in restitution. The physician, a native of West Africa who was in the U.S. illegally at the time, had billed for CAT scans he never performed.
- Nursing home operators in Pennsylvania and North Carolina have been convicted of charging personal luxury items like jewelry, swimming pools, and the family nanny to Medicaid cost reports.

- Physicians who are nothing more than drug dealers with prescriptions pads have been found in Philadelphia, Baltimore, Detroit and elsewhere, providing Medicaid recipients with addictive and medically unnecessary tranquilizers, painkillers, cough suppressants, and diet control pills.
- In Jacksonville, Florida, a psychiatrist who spent an average of less than 5 minutes with each patient, billed Medicaid for 45-50 minute individual psychotherapy sessions.

Perhaps even more important than any specific prosecution or recovery, however, is the fact that the Units have demonstrably deterred the loss of many more hundreds of millions of dollars in Medicaid overpayments. We have often witnessed a pattern of skyrocketing Medicaid expenditures followed by a sudden, sharp dollar decline in the wake of a Unit's investigation of a particular provider group.

In New York alone, for example, following intensive Unit enforcement activity and tough administrative action, annual State Medicaid payments plummeted dramatically in several provider categories - e.g., prescription footwear costs dropped from nearly $30 million to $3 million a year, and podiatric service claims fell from $35 million to $13.4 million a year -- a savings to the New York Medicaid Program of perhaps as much as $340 million in the past 7 years; and, in the most startling instance to date, statewide clinical lab billings crashed from a high of nearly $170 million in 1988 to just over $20 million in 1992.

I would also like briefly to share with you some of our findings in the area of patient abuse.

Scores of investigations and years of cumulative experience have made it clear that the abuse, neglect, mistreatment, and economic exploitation of nursing home residents is a problem of far greater magnitude than previously thought. Our national association, in collaboration with the National Association of Attorneys General (NAAG), has therefore promulgated a model patient abuse statute - already adopted in several states -- that would not only provide the necessary prosecutorial tools and enhanced penal sanctions for combatting this type of shocking misconduct, but would also serve as a powerful deterrent to potential patient abusers.

Let me highlight just a few examples of the Units' work in this area:

- A Baltimore doctor was sentenced to two years in jail for criminal neglect of his nursing home patients. As the facility owner and medical director, this physician failed to provide even the most basic medical care to his patients and refused to allow other doctors into the home to do so, leaving many of the residents with malnutrition, dehydration, and untreated bed sores.
- In Arizona, a residential care home owner was sentenced to serve 21 years -- the longest sentence for elder abuse in the state's history -- for neglecting and abusing his aged patients. To induce families to place their relatives in his facility, the defendant had lied to them about his nursing licensure status.

Two patients were thereafter hospitalized, and one had to undergo a leg amputation for life-threatening bed sores. Another patient was knocked down by the owner and broke her hip, but he refused to take her to a doctor.

- Four nursing home officials in Philadelphia were charged with involuntary manslaughter in the death of two nursing home residents who died from massive and infected bed sores.
- Beverly Enterprises, Inc., the largest nursing home chain in the nation, agreed to pay Oregon $600,000 and to improve care at their 17 facilities in the State, after a MFCU investigation of a Beverly home found evidence of inadequate staff training and supervision, and other conditions constituting an immediate threat to resident health and safety.
- The third largest nursing home corporation in Texas and the ninth largest in the nation, four corporate officers, and four employees were indicted on charges related to the death of two facility residents. One patient allegedly died from neglect, and the other, who suffered from senile dementia, was allowed to wander from the nursing home, became lost, and died of exposure.

And beyond these egregious cases of corporate and management neglect, the Units have also uncovered hundreds of incidents of individual nurses, aides, and orderlies raping, sodomizing, beating, kicking, and force-feeding the helpless, often incompetent patients in their charge.

Finally, it should be noted that Medicaid cases often have a significant Medicare or private insurance component. The Units regularly conduct joint investigations with a wide range of state and federal criminal justice agencies such as the FBI, OIG, Postal Service, DEA, DOJ, and U.S. Attorneys, as well as various state licensing and regulatory bodies. Of course, the Units also work cooperatively with each other and share information on multi-state investigations.

A perfect example of such a state - federal partnership was the recent successful investigation and prosecution of the La Jolla, California - based National Health Laboratories, Inc. (NHL), the largest health care fraud case ever concluded.

This nationwide marketing and billing scam began in 1987 when NHL "automatically" added a costly HDL-cholesterol test to every blood chemistry panel series ordered by a physician, ultimately causing huge losses to the Medicare, Medicaid, and Champus programs. NHL conducted business with 33 state Medicaid programs where there were MFCUs. These 33 Units supplied the federal grand jury in San Diego with witnesses and data demonstrating the true national scope of the scheme and, at the conclusion of the probe, were instrumental in formulating a global settlement that resulted in guilty pleas by NHL and its president, a $100 million federal recovery, and $10.5 million in restitution to the 33 affected state Medicaid programs.

Thus, increasingly over the years, the state MFCUs have come to be viewed as leaders in the detection and prosecution of fraud in the health care industry. Indeed, just last summer

NAAG adopted a formal resolution (attached) urging Congress to include fraud control as a significant priority in any health care reform legislation and citing the state fraud units as the model to be followed.

Under current legislation, the Units are funded on a 75% federal - 25% state yearly grant basis. The federal match is carried as part of the Medicaid program's administrative costs within the budget of the Health Care Financing Administration (HCFA), with the Units' funds subsequently transferred to OIG for distribution to the states.

In a cogent analysis of the proposed matching rate reduction, the Congressional Budget Office recently asked (1) whether the states still required "special incentives" for anti-fraud activities and (2) whether, if denied an enhanced match, the states might make "less effort" to eliminate Medicaid waste and abuse. Sadly, the answer to both questions is an unequivocal yes.

In practical terms, the proposed reduction would require a state to double its contribution from 25% to 50% just to maintain its Medicaid Fraud Control Unit at present strength. Coming at a time when cash-poor states are already unable to fully fund their Units -- let alone many other essential state programs -- this proposal would surely result in most Units either being dissolved or drastically downsized. The fraud units are people-driven, not computer-driven entities, and the states' likely response to diminished federal funding would simply be to cut personnel. In my own state, in fact, although annual Medicaid costs mushroomed from $3 billion to over $16 billion during the past 15 years, state budgetary constraints have forced the Unit's staffing level down by more than 33% since our original MFCU designation in 1978.

As far back as 1980, GAO studied this very issue and, while finding the Units to be an "effective force" in combatting Medicaid fraud, concluded that without continued 75% federal funding "many fraud units will probably cease to exist or operate at a reduced level of effectiveness." Indeed, even with the enticement of a 75% - 25% formula, most states have for many years chosen to operate their units at a funding level far below the maximum allowable federal reimbursement cap of 1/4 of 1% of a state's annual Medicaid expenditures. As a result, the federal government is today barely contributing $50 million a year -- or 1/28 of 1% -- to safeguard a program that is expected to cost over $140 billion this calendar year.

In sum, the Administration proposal, which would save at best $15-18 million federal dollars per year (based upon a projected $72 million total federal/state program), will wind up costing taxpayers -- not to mention the fiscal and moral integrity of the Medicaid program -- far more than it would save. The net effect would be a dramatic reduction in convictions, recoveries, and long-term deterrence, and substantially less emphasis on protecting the institutionalized elderly. Not only would this deal a crippling blow to the states' fight against fraud and abuse in the delivery of health care services, but would be particularly foolhardy in view of OIG's announcement only last week that it was ceasing federal Medicaid fraud investigations almost entirely and turning all new cases over to the Units.

Finally, I must reflect briefly on the prior history and current context of the instant proposal. The identical recommendation was first made by the Reagan Administration in the mid-80s and then again by the Bush Administration. The National Association of Attorneys General formally opposed any such reduction in the federal matching grant (see attached NAAG Resolution), and urged Congress to reject it -- which Congress did on both occasions. In fact, at one point, the Office of Management and Budget itself recognized the error of its ways and specifically exempted the fraud units from the proposed reduction plan.

Furthermore, for over a year now, there have been insistent calls throughout Capitol Hill for more, not less, enforcement in the health care system. The GAO has repeatedly stated that only a fraction of health care fraud and abuse is now identified and prosecuted, that the resources currently devoted to fighting health care fraud are too small, and that, without adequate resources, effective investigation is not possible.

Last year, the late Congressman Ted Weiss called for the creation of a national commission to map out a health care fraud strategy and said, "I do not understand how we can be cutting funds to oversee federal health insurance programs at a time when costs are rising at the speed of light."

Senator Biden introduced the "Health Care Fraud Prosecution Act of 1992" to attack "the multi-billion dollar problem of health care fraud" and underscored the need to make the prevention and prosecution of these abuses a "national priority."

And only last month, Congressmen Stark and Levin introduced legislation to establish a national health care fraud and abuse program.

Indeed, the President himself, in laying out his "Vision of Change for America" in February, talked of the billions of taxpayers' dollars being lost to fraud and abuse and vowed to "root out fraud and outrageous charges" from our health care system.

In closing, I want to emphasize that the Medicaid Fraud Control Units play a national leadership role in detecting and prosecuting fraud and abuse in government funded health care programs. The Units have been uniquely successful in deterring health care fraud, recapturing program dollars, punishing corrupt and incompetent practitioners, and preventing the physical and financial exploitation of the frail elderly. No other health care fraud enforcement effort has proved as efficient and effective for so long as have the state-based fraud control units.

The Medicaid system must not be returned to the defenseless posture it was in when Congress moved boldly and wisely in 1977 to implement a national Medicaid fraud control strategy. Nor must we send a message of weakened resolve to voracious providers that the Medicaid program is once again theirs for the taking.

At a time when health costs are rising relentlessly and the President is poised to deliver a health care reform package to the nation, it makes little sense to dismantle a law enforcement program that has not only been a model of federal-state cooperation, but has for many years demonstrated unmatched expertise and effectiveness in policing the health care industry. If slowing the growth of health care expenditures due to fraud and abuse is to remain, as it must, a serious objective of government, then gutting this remarkable program would be a tragic miscalculation.

As James Pinkerton wrote, cynically but insightfully, in New York Newsday just two weeks ago, "About 10 minutes after the president signs a bill, Americans will figure out how to 'game' the new system. The cleverest doctors and lawyers in the country will match wits with bureaucrats. Guess who will win."

Mr. Chairman, I firmly believe that the Administration proposal, if accepted, would impact adversely for years to come on the integrity and quality of health care for all our citizens, but most especially for the poor and elderly. I thank you for this opportunity to testify today and would be happy to try to answer any questions you may have.

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NATIONAL ASSOCIATION OF ATTORNEYS GENERAL

Adopted

Summer Meeting
July 8-11, 1992
Pittsburgh, Pennsylvania

RESOLUTION

HEALTH CARE FRAUD

WHEREAS, the cost of health care continues to rise dramatically every year and millions of Americans are uninsured and underinsured; and

WHEREAS, estimates of health care fraud in government and private insurance programs range from $80 to $100 billion each year; and

WHEREAS, health care fraud is of increasing national concern and a focus of both law enforcement and the private insurance industry; and

WHEREAS, Congress is considering numerous proposals to reform the health care delivery system in order to contain costs and to assure access to quality health care for all, and several of these proposals would restructure or eliminate Medicaid; and

WHEREAS, health care fraud has been the subject of numerous Congressional hearings and proposed legislation; and

WHEREAS, Medicaid finances the majority of long term care costs and with the aging of the population it is vital to continue to protect the quality of care of those sick and elderly who reside in health care facilities; and

WHEREAS, the states have demonstrated their success for more than a decade in investigating and prosecuting health care providers and in protecting sick and elderly residents of health care facilities from patient abuse and neglect; and

WHEREAS, the Medicaid Fraud Control Units of the states and the District of Columbia have demonstrated their ability to coordinate their resources with other state and federal agencies, which is necessary to successfully prosecute these crimes; and

WHEREAS, if Congress adopts a new health care financing system that eliminates Medicaid, the government will still be significantly involved with financing health care, there will be enormous sums of money involved, and there will continue to be unscrupulous providers who steal public funds; and

WHEREAS, Congress should establish integrated law enforcement units that have statewide authority to prosecute providers for criminal violations and should include these state investigative and prosecutorial entities immediately in any proposed health care reform legislation;

NOW THEREFORE, BE IT RESOLVED THAT THE NATIONAL ASSOCIATION OF ATTORNEYS GENERAL:

1) urges Congress to continue to maintain state investigative and prosecutorial entities in any new health care reform legislation; and

2) urges Congress when adopting fraud and abuse legislation to use the Medicaid Fraud Control Units of the states and the District of Columbia as a successful example of state/federal and private sector cooperation in investigating and prosecuting health care fraud; and

3) urges Congress to include in any health care reform legislation the authority to prosecute patient abuse and neglect of the elderly in health care facilities and in home health care programs at the state level; and

4) authorizes the Executive Director and General Counsel to transmit this resolution to the Administration, appropriate committees of Congress, and other interested individuals and associations.

5) directs NAAG to establish a subcommittee of the Health Care Task Force which would include representatives of the National Association of Medicaid Fraud Control Units to make recommendations for further action.

NATIONAL ASSOCIATION OF ATTORNEYS GENERAL

Summer Meeting
Seattle, Washington
June 9-12, 1986

RESOLUTION IX

PROPOSED REDUCTION IN FEDERAL FUNDING FOR MEDICAID FRAUD CONTROL UNITS

WHEREAS, the Administration's FY87 Medicaid budget as transmitted to the Congress by the Office of Management and Budget, proposes to eliminate all special matching rates for state and local cost of administering the Medicaid program, thereby reducing the federal financial reimbursement of state Medicaid Fraud Control Units from 75% (90% in the first three years) to 50% of Unit costs; and

WHEREAS, the Medicaid Fraud Control Units have demonstrated their success in investigating and prosecuting Medicaid providers who enrich themselves illegally out of publicly funded health care programs, and have returned significant amounts of money to the federal, state and local treasuries; and

WHEREAS, the efforts of the Fraud Control Units have had a documented and demonstrable effect in deterring fraudulent conduct by Medicaid providers, thereby further saving American taxpayers significant sums for investment in needed health care services; and

WHEREAS, the proposed reduction in the federal share of the program would require the states to double their investment in fraud control in one year, a level of increase most states would be unable to fund, thereby resulting in a loss of personnel and seriously impeding the work of the Units; and

WHEREAS, the Office of Management and Budget has also proposed that the administrative responsibility within the Department of Health and Human Services for supervising state Medicaid Fraud Control Units be transferred from the Office of Inspector General to the Health Care Financing Administration, which does not have experience in law enforcement;

NOW, THEREFORE, BE IT RESOLVED, that the National Association of Attorneys General:

1. Opposes the proposed reduction in the federal matching rate for the Medicaid Fraud Control Units and urges the Congress to reject the proposal to cut the federal matching rate; and

2. Opposes the Office of Management and Budget's proposal to transfer the administrative responsibility for the state Medicaid Fraud Control Units from the Office of Inspector General to the Health Care Financing Administration; and

3. Urges Congress, if necessary, to enact legislation that would continue the Inspector General's administrative responsibility over the state Medicaid Fraud Control Units; and

4. Directs the Executive Director and General Counsel of the National Association of Attorneys General to make these views known to the Congress, Attorney General Meese, the Secretary of Health and Human Services, other members of the Administration, and other interested parties.

Mr. WAXMAN. Thank you very much, Mr. Kuriansky.

Ms. Frank.

STATEMENT OF BARBARA FRANK

Ms. FRANK. Thank you.

My name is Barbara Frank, and I am here to speak for the National Citizens' Coalition for Nursing Home Reform. My job is to put these cuts in human terms, and I guess that while you all sit up there at the top of the podium and we sit down here in the audience, there is one thing that we all have in common. At this very moment, each of you and each of us is aging, and there is no way we can get around it. Although only the good die young, as they say, some of us are likely to have a long and healthy life and then at some point need nursing home care.

The nursing home reform law was one of the most dramatic and positive public policy events that happened in this Congress. It has an opportunity to make a real difference for human beings that are living in nursing homes now. The reform law has a very, very simple premise: People should not get worse because of what the nursing home does to you; if anything possible, should get better or at least stay at the health level and maintain the best possible well-being that they can have.

Now let me ask you as you sit up there on your podium. You sit in a lot of meetings; you sit and you listen for a long period of time. Undoubtedly, you start to feel pretty stiff, don't you? You start to need to stretch and to move around. Well, picture a nursing home resident, 85 years old, sitting in a chair day after day after day, physically tied in their chair, perhaps sedated because they have resisted their restraints. After a while, you don't just get stiff, you get contractures, you get skin breakdown, you get incontinence. It is a natural consequence of being restrained, it is a natural consequence of a poor care practice, that you are led down a path of basically deterioration and death.

There is a man sitting here in this room with me today named Jim Lambert who watched his father die that way over a 1½ year period. He watched his father, a robust 180-pound man, try to walk to the door with Alzheimer's, and he was called a wanderer, so the nursing home brought him back in and sat him in his chair. Well, he didn't want to sit in his chair, he wanted to walk. He got brought back in and sat down in his chair again. He resisted those restraints, so he was sedated. After he was sedated and tied down in his chair, he couldn't go to the bathroom when he needed to, so he was called incontinent; he was catheterized. A year and a half later, he died in a fetal position at half his body weight with contractures, bed sores, urinary tract infections, broken hip, all avoidable.

What stands in the way of that kind of care for everybody is the survey process, the inspection system. It doesn't work perfectly right now. In fact, it needs tremendous investment of training, of qualified surveyors, the ability to be responsive to complaints. But it is that system which is going to make the difference between having more Mr. Lamberts and having more people who are able to walk freely, pursue activities, and thrive despite their illnesses and their old age.

You sit in your chairs, and you have the opportunity to decide whether other people are going to be sitting in their chairs for the rest of their lives or be able to live with some fulfillment and some identity and some safety and security before the end of their lives.

So even though the buzzer hasn't gone off, I'll leave my comments there, just to say to you that the proposal would essentially cut survey costs in half and mean that surveyors would not be able to respond to consumer complaints, they would not be able to have the training that they need to be able to see those situations that Mr. Lambert experienced and be able to stop them.

We have the opportunity with a good reform law to make a difference for older people in nursing homes, and it is up to us whether or not we have the political will to enforce it.

[Testimony resumes on p. 325.]

[The prepared statement of Ms. Frank follows:]

Statement of Barbara Frank, Associate Director, National Citizens' Coalition for Nursing Home Reform

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TESTIMONY OF

BARBARA FRANK, ASSOCIATE DIRECTOR

NATIONAL CITIZENS' COALITION FOR NURSING HOME REFORM

My name is Barbara Frank. I am testifying on behalf of the National Citizens' Coalition for Nursing Home Reform. NCCNHR advocates for quality of care and quality of life for nursing home residents. The Nursing Home Reform law of 1987 provides the foundation for better care. It represents sound public policy derived from exhaustive review of best professional practices. Though unevenly applied, it has begun to make a difference in the lives of residents.

There are two key ingredients necessary for Implementation of the law: (1) comprehensive education and training for providers, professionals, surveyors and consumers; and (2) accurate surveys and effective enforcement of the law. Oftentimes, it is the threat of enforcement that leads providers to be receptive to education. That enforcement is not yet fully functioning and today, is at risk, because of the proposal before this Committee.

We are here today to express our alarm and opposition to the administration's proposal to cut the enhanced administrative match for survey and enforcement activities. The Budget proposal could have the effect of cutting state capacity the survey and enforcement activities in half, at a time when there is absolutely no margin for cuts. Such a cut could jeopardize the potential for the Nursing Home Reform law to fulfill its promise of better care for institutionalized Americans. A few survey dollars saved could result in grave harm to the 1.4 million Americans living in nursing homes. In the end, we will pay again and again for these cuts through the increased service costs needed to pay for residents left vulnerable and made sicker by poor nursing home care.

About the Reform Law

In 1987 Congress enacted landmark legislation: the Nursing Home Reform Law. The law has a simple premise: nursing homes should provide care and services to help residents maintain their maximum potential health and well-being. People should not decline physically or mentally while living in a nursing home, unless that decline is unavoidable -- a natural progression or outcome of their condition. Why is such a premise so powerful? Because for years, people who have lived in nursing homes have faced slow and painful deaths in isolation and degradation. People with dementia who were energetic or restless were called "wanderers" when they wanted to walk and restrained in their chairs, for "safety" because staff did not have enough time to walk with them. Frail people were restrained so they would not fall because the staff did not have enough time to provide them with physical therapy, and besides, they were "too old" for therapy. Hence a visitor to a nursing home would see older people strapped to their chairs, staring into space, silent, or moaning, out-of-touch, waiting to die.

I use the past tense for this description, not because this no longer occurs but to recognize that, with the Nursing Home Reform law, we have begun to see changes. According to nursing home self-reports, physical restraint use has been cut in half since the law went into effect. This has occurred because of a combination of education and enforcement. Across the country for three years now, nurses, doctors, social workers, activities professionals and therapists have attended programs on how to change their care practices related to restraint use. They have learned not just to find a "more humane" way to restrict someone, but how to assess a person's needs and provide activities for a bored person with dementia, to walk with a resident who wants to walk, to restore the function of a frail older person. And providers have had to learn these lessons because state survey agencies have cited them when they haven't. Misuse of restraints is among the top ten most frequently cited deficiencies in the country. Yet, so much more change is needed before we can assure that every nursing home resident receives good care. We still have significant avoidable problems such as dehydration, malnutrition, incontinence, bed-sores, depression, isolation and boredom, which are more often caused by neglect than by the natural progression of an individual's condition.

These poor care practices are costly, while doing a better job does not necessarily cost more money. In the case of restraints, it is well-documented that nursing homes can improve their care within the same operating budget. Instead of having staff mop wet floors, nursing assistants spend their time walking with residents and residents are able to get to the bathroom when they need to. Instead of chasing people away from the door all day, staff walk with residents at times of day residents most often want to walk. It is certainly important to discover that nursing homes can do better with the same money. But more astounding is the realization of how much money providers have been throwing away through poor care practices. A restrained resident declines rapidly. Think about it. How stiff do you feel after sitting in your chair for hours on end? Residents can experience the bad effects of immobilization within a matter of days -- muscles contract; bone tissue disintegrates; skin breaks down; so does the urinary tract system, and the cardiovascular system. Within weeks of immobilization individuals experience what is known as "iatrogenesis" -- it's a Greek word that means "We caused it." We cripple people -- in the name of "safety." With the excuse of not enough staff, we make people totally dependent on staff for the simplest daily functions.

The cost of such poor care is high. Hospitalizations or increased dependency on nursing home staff assistance costs money. We pay more than $3.26 billion annually for incontinence in nursing homes; we spend billions of dollars annually treating preventable pressure sores; and billions more on hospital treatment of nursing home residents who suffer hip fractures (at an average of $26,400 per fracture as long ago as 1985).

Under the Nursing Home Reform law, these care practices are illegal. These people have declined because of what the nursing home has done to them, not because of a "natural progression" of their condition. But this has only changed because the Reform law is beginning to be enforced, and providers are therefore learning more about what they have to do to comply. If we cut back on enforcement, we will nip this change in the bud. We will allow the crippling of institutionalized Americans to continue and regain its ground as common practice. We will pay the consquences -- in human suffering, unnecessary costs, and unnecessary destruction of human bodies and spirits. A small investment in our enforcement system has a big pay-off in assuring that our billions of dollars for health services are well-spent.

A Total Enforcement System

The proposal to cut the survey budget will make it impossible to support the total enforcement system demanded by the law, and required if we are to ensure proper health expenditures. The Nursing Home Reform law draws extensively on the work of the Institute of Medicine's 1986 report, "Improving the Quality of Care in Nursing Homes." That report indicated that changing nursing home care will require action on four fronts -- (1) good standards of practice; (2) accurate, reliable surveys; (3) effective enforcement; and (4) knowledgeable consumers supported by a strong ombudsman/advocacy network.

The report, and the law, require sweeping changes in our survey process, just as they require changes in how nursing homes operate. The report echoed a decade of criticism that the survey process focused more on paper than on people, more on plans than outcomes. To redirect the focus of the survey process, Congress required that surveyors look at the care residents are receiving, and how that care affects their physical and mental well-being. In other words, don't look for good charting, look for good results. If people are dying in restraints but all the medical orders are in place, the facility should be cited for the care outcomes, not let off the hook because it is well documented.

Congress required states to make extensive changes in order to have the capability to evaluate facility care and resident outcomes. The Reform law requires states to have the capacity to respond quickly to complaints, to monitor poor-performing facilities, and to return to facilities with problems as often as necessary. It requires states to build their survey force by hiring well-trained and qualified surveyors representing a variety of professional disciplines. States must provide educational programs for providers, consumers and their survey staff. And states must have a range of sanctions available to respond to the range of problems identified in facilities.

Other programs, such as Medicaid Fraud Control and the Long Term Care Ombudsman Program are critical ancillaries to the regulatory system. Surveyors must be able to rely on Medicaid Fraud Control Units for criminal investigations and prosecutions when fraudulent or abusive situations occur in nursing homes. Surveyors must also be able to rely on the on-going Ombudsman presence in nursing homes to extend the eyes and ears of surveyors beyond their annual visit. None of these other programs can be fully effective without a well-functioning survey system. And the survey system must have the resources to work collaboratively with these other programs.

The Health Care Financing Administration has revised the survey process to reflect the "outcome-oriented" focus of the law. Surveyors are required to consult with the ombudsman program, talk with residents and families, and check out their findings with staff. They must review the environmental quality of resident living space and group spaces, assess the quality of care and dietary services, medication administration and adherence to residents' rights for a sample of residents. The HCFA survey procedures help surveyors ask the question "Why?" -- "Why is it that this person could walk when he was admitted, and now can no longer walk?" "Why is it that this resident lost weight, or became disoriented, or withdrawn?" The procedures take the premise that residents should, at the very least, maintain their level of functioning and directs surveyors to ask "Why?" when residents decline.

But it has not been an easy transition. Surveyors have not yet had enough comprehensive and sustained training and supervision to support this refocus. In states which have begun efforts to implement the law in its fullest spirit, we have found improvements in resident physical functioning and psychosocial well-being. Yet this has not come easily. It has required intensive training and reorientation of mind-sets.

For example, the state of Washington has invested federal and state survey dollars in a multi-year effort to apply the law in its survey and enforcement program. State officials initiated a comprehensive effort, including educational programming for surveyors, providers, and consumers; hiring experienced, qualified surveyors, with initial efforts to diversify the professional make-up of the survey teams; instituting a multi-faceted quality assurance program which allows the state a frequent presence in facilities; conducting surveys on weekends and at night when necessary; and working closely with the ombudsman program. The results, according to consumers, are an impressive start to bring the promise of nursing home reform to their state.

Washington state has used a range of enforcement mechanisms including bans of admission, fines, monitors, and temporary managers, to straighten out poor care situations. The state is finding it more cost effective to attend to individual problems before they become patterns and to fix problems early, rather than to wait until they are so bad that costly remedies like temporary management are necessary. It may be a telling sign that the nursing home industry lobbyists in Washington state are now attacking the state's enforcement and its record of the high deficiency citing levels on certain residents' rights and quality of care issues.

Washington state has spent its federal dollars wisely and begun to improve the quality of life for its citizens in nursing homes. It has also been successful in defending the adequacy of its reimbursement rates in court in response to an industry lawsuit. Hence, it is using the investment of survey dollars to save in overall spending in the Medicaid program. But Washington state, in the midst of a fiscal crisis, cannot afford to double its level of effort, if the federal government reduces the percent of its contribution. The state may not be able to maintain its effective enforcement of program requirements. We do not save tax-payers' dollars if we allow poor care practices to drive up the nursing home's bills to the public coffers.

The nursing home trade associations have lobbied agressively to place impediments in the way of the enforcement system. They want additional procedures that, in our view, would obstruct enforcement and could grind the system to a halt. The trade associations have also offered extensive programs for their memberships on how to "manage" the survey process and "respond" to survey findings. They have upped the legal ante and recommended that providers routinely disavow responsibility for deficiencies and pursue all avenues available to get deficiencies erased from survey reports. It is a shame to be faced with this outright defiance of the reform law, done under the guise of "due process." It is especially shameful when we see what a tremendous difference it can make for residents and staff alike, when providers set their mind to changing poor practices instead of defending them.

Even without the provider assault on the survey system, the system would need the full federal funding now available in order to develop the capacity to fulfill its mandate. In the face of this intensive provider opposition, which is eating up resources defending against often belligerent assaults by providers, the resources are needed all the more. To take monies away now is complicity with the nay-sayers in the provider community. Such a proposal leaves surveyors without the resources to apply the law and continue on the road to reform.

The Proposal Cuts To the Bone

The Administration proposes to reduce the federal contribution for the Medicaid survey budget from 75% to 50%. This, on its face, is alarming enough. Yet it is deceptive. The real effect will likely be to cut the Medicaid survey budget in half because many states will not be able to double their contribution to the budget. If Medicaid dollars are reduced, the Medicare dollars in dually-certified facilities will also be reduced. We could actually see, in many states, as much as a 50% cut to the overall budget. Here's the math:

The federal Medicaid match is predicated on the state's commitment to fund the balance of the program. Now, if the survey program costs $100, the federal government pays $75 and the state pays $25. The President's budget proposes to drop the percentage of the Medicaid match to 50% and therefore the federal Medicaid contribution to $50. But in order for a state to get that $50, it will have to double its contribution from $25 to $50. A state which cannot do so, but can maintain its current contribution at $25, will only receive $25 from the federal Medicaid program. Its overall Medicaid budget will be cut from $100 to $50. The Medicaid budget pays for approximately half of the state's federal survey activities; therefore the state's survey budget will be cut by 25%. Once Medicare sees the drop in survey budget amount, it could drop its level to $50 as well, leaving the total budget cut in half.

Given the careful calculations that went into the funding levels for the survey budget in the first place, it is hard to see where states will have a margin to cut activities. For instance, California's preliminary estimate is that it will lose $4.3 million dollars in its Medicaid budget alone. It expects to have to cut about 10% of its survey personnel, not to mention supervisory staff who make sure the program functions at a high quality level. In order to keep federal dollars, states may shift money away from other survey activities, like responses to complaints, inspections of hospitals or home health agencies. Minnesota predicts it would have to reduce its nursing home surveys, follow-ups and complaint investigations by 46%. Illinois predicts a loss of $1.5 million, resulting in a loss of a third of its survey staff. Arizona reports that its entire Long Term Care program would be devastated.

These are just projections of lost personnel and explicit survey functions. What about the quality of those functions? the training and quality management required? While training and quality assurance programs cost money, they provide a return for the money by assuring that our billions in health care dollars are appropriately spent. Yet those efforts will be lost if the federal match is cut. States are struggling now to maintain the level of their contribution, but few will be able to make up for the loss of federal funds.

Current federal budgeting for the survey process is very tight, without any margin for cuts. Medicaid expenditures for states are based on estimates from the Medicare budgeting methodology, which uses a carefully prescribed unit cost formula. The Health Care Financing Administration calculates the number of initial surveys, recertification surveys, follow-up surveys and complaint investigations a state will need to conduct annually. The budgeting formula uses time parameters by facility type based on on-site experience using the federal survey protocols. Time spent on preparation, travel, on-site inspection, documentation of deficiencies, supervisory review and clerical support are calculated.

Federal protocols call for a team size ranging from 2 to 4 surveyors for long term care facilities with 200 or less residents, and 4 or more surveyors for long term care facilities with more than 200 residents. Survey tasks take three to four days. While the survey process takes time, it gives surveyors the opportunity to find out what is really going on, rather than review the paperwork.

The quality of implementation of the current survey process has come under attack. The nursing home industry has criticized the "inconsistency" of the surveys and released a study indicating great variation in deficiency-citing across the country. At the same time, the nursing home trade associations are using the weaknesses in the current system to push an agenda to disable the enforcement system.

Consumers are also concerned about the quality of the survey process. Quality caare problems abound, as reported to ombudsman programs and our organization by individuals whose faily or friend lives in a nursing home. Yet states say they fear industry litigation and so are hesitant to cite. At the same time, states which do apply the law more aggressively, such as Washington state, are threatened by industry political assaults. Consumer complaints are not always investigated thoroughly or in a timely fashion. "No time," the states tell us. We need a more effective, more available survey system. We cannot afford any cuts in the system.

Such a proposal may seem "penny-wise" but is certainly "pound-foolish." Such a proposal is not only fiscally unwise; it is irresponsible in light of the public duty to protect the rights and welfare of vulnerable individuals living in nursing homes.

A Case in Point

Allow me to give you an example of the high cost of cutting the survey budget and allowing poor care to flourish. Mr. Jim Lambert visited our office a year ago desperately trying to find help to turn around the care his father was experiencing. The following was reported to us by Mr. Lambert, who is here in this room with us today, and by an independent nurse who reviewed the record in preparation for a tort case:

> Prentiss Lambert was a robust 182 pounds, active and energetic though suffering from Alzheimer's disease. When the staff could not keep him from heading for the door, they tied him to his chair. When he resisted the restraints, he was tied more securely. When he tried, still, to stand, and fell, he was sedated. Then he couldn't go to the bathroom when

he needed to so he began to soil himself. The staff called him "incontinent" and catheterized him. He tried to pull the catheter out because it irritated him and he was further restrained. He lost his appetite, lost his vigor, lost his spirit.

When Prentiss Lambert died a year and a half later, he weighed 94 pounds and his body had contracted into a fetal position. Before he died, he underwent treatment for a broken hip from a fall, bedsores, urinary tract infections -- all potentially avoidable if he had been allowed to walk, to function, to do what he could still do for himself.

Jim Lambert made repeated complaints to the state health department. When the state survey agency answered the family's complaint and reviewed Mr. Lambert's care, the surveyors were still operating under an old paper-compliance mind-set. Investigators confirmed some of the complaints, sometimes requiring minimal correction. For instance, on an October, 1991 survey, surveyors questioned the poor documentation on medications, but did not question how Mr. Lambert had gotten in such bad shape and why the chemical restraints were used.

The survey report reads: "Documentation of residents receiving antipsychotic drugs was found to be inadequate as the monitoriung sheets were not consistently written."

What's the facility's plan of correction? "Mandatory inservice" and "better documentation."

And at the bottom, the facility notes that "Submission of these responses to the State ment of Deficiencies by the undersigned, does not constitute an admission that the deficiencies existed and/or were corrrectly cited and/ or require correction."

In June of 1992, three days after Mr. Lambert's death, the HCFA Regional Office inspected the home and effectively used the survey standards of the Nursing Home Reform law. It cited four Level A deficiencies, meaning the facility failed in an entire category of requirements -- for

Resident Behavior and Facility Practices, Resident Assessment, Quality of Care, and Administration. Six months after the state's survey resulted in a two page report, the federal surveyors wrote 43 pages describing the conditions they had found, not just for Mr. Lambert, but also for several other residents still living at the home.

Because the federal government has not yet implemented the enforcement portion of the 1987 Reform law, no penalties were imposed on the home for its poor care. As far as we know, the home's operations remain virtually unchanged while other vulnerable individuals continue to live there.

As Jim Lambert told me, "What happened to my father is a matter of public record. What's shocking to me is that nobody did anything about it." While this sounds like a story of system failure, the fact that the federal surveyors did identify the real problems gives us hope. Once we have enforcement remedies in use, those surveys could actually change care practice. But the remedies will be useless if the survey budget is cut and situations like Mr. Lambert's go uncited.

Our files and the ombudsman program's files are full with reports of neglect. Across the country, nursing home residents experience physical decline and emotional withdrawal because of everyday, avoidable neglect. Such care may be penny-wise, but it too is pound foolish. And it is exactly these circumstances which the 1987 Reform law clearly addresses. Developing and maintaining an effective survey and enforcement system requires an investment of public dollars. Such an effective system is the only hope for nursing home residents. The proposed budget cuts would cripple efforts to extend to nursing home residents the full protection guaranteed by the federal law.

Conclusion

Effective quality assurance is a necessity in our health care system, and particularly so for nursing home residents who are often powerless to exercise the simplest control over basic aspects of their daily lives, let alone to protect themselves from neglect or abuse. Congress wisely enacted the Nursing Home Reform law in 1987 to establish a standard of care and a system for enforcing that standard. It has taken almost six years to put the pieces of the law in place and now we are just beginning to enforce it and reap the rewards of this sound public policy. Yet the impediments to enforcement of the law are fierce and we are at risk of reducing the law to empty words if we do not back those words up with accurate surveys and effective enforcement.

Throughout the Reagan-Bush years we faced proposals to cut nursing home oversight, not dissimilar from the proposal before the Committee today. Such cuts in quality assurance don't really result in savings. In fact the opposite is true. When we cut back on quality assurance, we lose quality in our services and experience financial exploitation by providers. Yet, that is not the only cost. When we allow nursing homes to provide poor care, we undoubtedly have higher service delivery costs. Poor care makes people sicker and more dependent, and more costly to care for.

Cutting the survey budget is not "shared sacrifice." It's fiscal irresponsibility. We don't need cuts. We need more surveyors, more training, more quality management of the survey programs. We need support for new HCFA efforts to increase the quality of surveys. HCFA has instituted nationwide training for surveyors on more effective deficiency writing and is developing other training programs on quality of care and residents' rights issues. Some states have conducted additional training for surveyors. Ohio's surveyors received extensive training in investigative skills and now that program is being adapted for the federal level. These programs may not survive if the proposed cuts in the survey budget go through.

We are just now beginning to implement the Reform law and challenge uncaring practices that have been the norm for too long. Investment in the survey process is the critical step to making the law a reality. Congress was so sure of the importance of the survey system that it increased the federal match beyond 75% for the first years the law was to take effect. Thereafter, Congress decreed, the federal contribution was to remain at 75% because of the federal responsibility for implementation of this significant public policy. With full federal participation, it will likely take a decade before we see real change in nursing home quality across the boards in this country. Without that investment, it is possible that the law will never really be applied.

When our regulatory system fails, people like Mr. Lambert's family must turn to the legal system for redress. Tort litigation can only be brought after harm has occurred. A private right of action can also be an important legal tool to stop poor care practices. It has not yet been recognized by the court, despite language in the Reform law that supports the existence of such a right. Still this right of individuals to pursue legal remedies is no substitute for an effective regulatory system. Many people do not turn to the legal system, and just suffer silently the indignities of neglect.

We pay for their suffering. We pay in the bankruptcy of our collective social conscience. We pay in unnecessary hospitalizations. We pay in higher rates that nursing homes redirect toward profits or spend on custodial care for people crippled by the neglect. We know how to stop poor care. We have the law on the books to do it. But do we have the political will to do it? We cannot afford not to. Thank you.

Mr. WAXMAN. Thank you very much for your testimony.

Let me challenge this panel by indicating that yesterday when the administration testified they said that this enhanced administrative matching rate—and I quote—"has already served its purpose, and there is no longer a need to motivate States to continue their efforts in these areas." The acting HCFA administrator, Mr. Toby, also argued that reducing matching rates would—and I quote—"be a stimulus to the States to be more efficient and creative."

The implication of this argument is that there is a lot of fat and waste in the State administrative spending and that the way to cut it out is to reduce the Federal matching dollars. Of course, if some States are inefficient, the administration proposal hits the well-managed State programs just as hard as it hits those that are poorly run. So if the point here is to get rid of the fat, this doesn't seem like a very intelligent way to go about it.

Dr. Smith, Mr. Kuriansky, how would you respond to Mr. Toby? Will this stimulate you to be more efficient and creative in administering the program or in seeking those who are committing fraud against it?

Mr. SMITH. Mr. Chairman, to begin with, I don't think I would use the word "creative." We are doing about as much as we can with the word "creativity." I think one of the things we looked at with our budget process in the State of Texas, the word "draconian" came out once or twice.

What it would force us to do—and, again, we are going through the same kind of initiatives that people have talked about here to try to protect areas in the regulatory, whether it be long-term care, intermediate care facilities for mentally retarded, and our fraud and abuse units, that something would have to give. Given the fact that the budget will be balanced and there are no dollars, what is going to give is services or, in fact, we will give on the side of not regulating an industry and looking at the quality of care. But something will give because the dollars won't be there, and what will suffer will be the people we take care of.

In the case of children and pregnant women, if we take it from there, all Texas will do is ensure that more pregnant women and children will be uninsured, and we already lead the Nation in the category of uninsured children, and in the case of nursing homes, I'm sorry to say, I don't want to be set up to have another 20/20 expose, and certainly we are trying with our bad actors bill and others to get in place some effective rules and regs, but we are not going to be able to regulate and use those and look at the homes and what they are doing.

Mr. WAXMAN. Mr. Kuriansky.

Mr. KURIANSKY. Mr. Chairman, as a lawyer, I'm very glad I didn't have Mr. Toby's side of the argument to make. There is absolutely no way the States will make up this difference for the fraud units. The fraud units are completely people driven entities. I have spent far too much of my time in the last 3 years up in Albany arguing, pleading, to retain our funding, staffing, level as it is, even with the 75 percent enticement. In fact, it is only the existence of the three-for-one match that has kept the wolves away from the door this long.

Mr. WAXMAN. That is hard to believe. A State certainly doesn't want to pay money for fraudulent claims. Don't they have an interest in trying to beef up your unit?

Mr. KURIANSKY. Absolutely. We are far understaffed. We are so far under the recommended cap set by the Congress when it enacted this legislation, it is ridiculous, and every State in the country can say the same thing, but the States are cash poor. They don't care if you save them money. You can go in and tell them that, "We put people in jail, we save you money, we bring back money, we deter the loss of money," and they say, "But you've got a hundred people, and they cost us x, and even though the Federal Government is paying three-quarters of it, we want to save one more dollar." That is the budgetary state of mind that you are greeted with today.

Mr. WAXMAN. Let's look at the math of this. We are talking about dropping a 75 percent matching rate to 50 percent. That would require a State to double its contribution just to keep the same level of resources in place, whether the activity is nursing home surveys, fraud and abuse control, or management information systems.

Now your respective States of Texas and New York, are considered wealthier than other States. But as hard as it will be for you to make up your lost Federal resources, I can imagine it would be even harder for relatively poor States like New Mexico or Tennessee to do so.

Mr. Kuriansky, you testified that if we were to adopt the administration's proposal, most State fraud units would either be dissolved or drastically down-sized because States would simply cut personnel. Let me ask you about the units that might survive extinction. Of your two basic functions, prosecution of fraud and prosecution of patient abuse and neglect, which would be more likely to be damaged?

Mr. KURIANSKY. The first to go would certainly be patient abuse. Even now there is sort of a pressure, I think, to spend your resources where you can bring back the most dollars, and I think if staffs were cut in half the way they would be under this proposal, patient abuse and neglect would clearly suffer, number one, but all the fraud investigations as well would probably go down the tube.

Mr. WAXMAN. Thank you very much.

I have other questions, but we are going to move on.

Mr. Greenwood.

Mr. GREENWOOD. Thank you, Mr. Chairman.

Dr. Smith, I think you made the statement in your testimony that the Texas budget is in the ditch. Does Texas have a debt?

Mr. SMITH. Yes. We are looking, as we are headed into this biennium, just in Medicaid alone, at almost a $2 billion shortfall, and it has to do with the same factors that Ms. Riley talked about: increasing number of eligibles because 20 percent of Texans now live below 100 percent poverty; medical inflation; and, of course, the need for things such as long-term care and other things. So we are seeing a growth in the budget in that other 97 percent.

Mr. GREENWOOD. Let me interrupt you. States experience shortfalls, but do you have a balanced budget amendment in Texas, or do you have a balanced budget requirement in your constitution?

Mr. SMITH. Yes, we do, which puts added burden to get to that point or to cut services, which is what we are looking to do now.

Mr. GREENWOOD. So you don't have a debt, you have a shortfall in the current fiscal year that you will have to figure out; you either raise taxes or cut spending somewhere else.

Mr. SMITH. Or cut services—correct.

Mr. GREENWOOD. Well, I would make the comment that if Texas's budget is in the ditch, the national budget is in an abyss—a canyon.

Mr. SMITH. We are probably in the same thing, yes.

Mr. GREENWOOD. Right. And I would submit to you that if we don't make the $1.7 billion in administrative cutbacks that the administration has proposed, then we have to find the $1.7 billion elsewhere, and we are going to find a lot of it in Texas, and the Texas and the New York taxpayers are not going to avoid the tax bill that comes due to pay for this. It would seem to me that one of the reasons that the administration argues that, in fact, these kinds of cutbacks can induce some efficiencies is because, as the gentleman from New York stated, his State officials are in looking at his budget and saying, "You've got to cut another dollar; you've got to cut another dollar." If the money comes from the Federal Government, you can be pretty sure that neither Chairman Waxman nor I will be down there telling you to cut another dollar because we don't do that, and I would just like the response of each of you to those kinds of observations.

Mr. SMITH. Again, looking at what our State is going through right now, I would go back to what I think is most likely to happen, and none of this happens in isolation. This is actually—we use the words "trickle down," but the question is, will we save any money? That really has to be the question that is asked: Will these cuts really save money? And I will argue that they won't.

As a practicing physician also, I will tell you that, what will happen, whether you cut services or you lose the opportunity to look at where people aren't getting the care they need or even in the site they should be, they may be in the more expensive site, like long-term care versus community care—those kinds of things—but someone ends up paying.

If you cut services and we drop back the number of pregnant women and children, because we will balance our budget, at the local level or at the Federal level, someone will pay for a bad baby outcome or something more tragic, they will pay for a mother who has a bad outcome for a pregnancy, but somehow you will pay and the cost will be greater, and I am very concerned, because that is coming out of the 97 percent as opposed to, in our case, the 3 percent administrative.

I think we are looking at the tail and not the dog as far as where the dollars are. They are not in these units. They will be the targets because it is very sexy to cut administration, but when you are running 3 percent administration you are getting to the point where you will make the program so inefficient and ineffective that it will actually pay for people not to get services, which is what we are doing now.

Mr. GREENWOOD. Do you feel more confident that you can leave your State of Texas and come to Washington and persuade the

Congress to make these expenditures than you would be if you stayed at home and tried to convince your State legislature to do it?

Mr. SMITH. I have to do both.

Mr. KURIANSKY. Mr. Greenwood, if I could respond, I think you have to understand, the fraud units are slightly different here. We are not part of the administration of the program, and, in fact, we save far more than we cost; we return money to the State and Federal treasuries.

I think you should know that, as it is now, the Federal Government is spending a paltry $50 million a year on the Fraud Unit Program to safeguard the Medicaid program in this country which is going to cost $140 billion this year. That is 1/28th of 1 percent of the Medicaid program costs are spent on fraud and abuse control, and the suggestion here is to save another $15 million. One investigation in New York in a single year saves far more than $15 million.

Mr. GREENWOOD. That is why I think that the chairman's question was on point. Why is it that you can't persuade the folks in New York that they have an interest in saving these kinds of funds? We have the great capacity to be more far-sighted than they because we write rubber checks and they don't.

Mr. WAXMAN. Thank you, Mr. Greenwood.

Mr. Brown.

Mr. BROWN. Thank you, Mr. Chairman.

Ms. Frank, you mention in your written statement that poor care costs money, and you mentioned that we pay more than $3 billion annually for incontinence in nursing homes and billions of dollars more treating preventable pressure sores—that sort of thing. Have you seen any reductions in cost for acute care services that you can sort of quantify for us as a result of the 1987 nursing home reform law?

Ms. FRANK. What we have seen is that nursing homes that have not had increases in their reimbursement rates have been able to provide better care with the same amount of money, and because the Medicaid and the Medicare budgeting is kept so separate, you are not able to quantify yet that there have not been those hospitalizations, there have not been those treatments that are generally happening in a hospital. For some reason, by you all up here, they are treated like apples and oranges when for us it is all dollars, it is all the same.

But we are starting to have some research that is being able to document that for the same money you can do a much better job, and it is just like we know in any sound business that doing a poor job is eventually wasteful of our dollars.

So we would be happy to supply you with some of the research that is starting to come out and be able to show you the time that is saved on better care practices and the time that is reallocated into better care.

Mr. BROWN. Thank you.

Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you, Mr. Brown.

Mr. McMillan.

Mr. McMillan. Just one comment on the issue of fraud. It seems to me that what you can't measure is what you prevent, and if you have an assertive anti-fraud effort, that discourages other activities, and that is not a measurable event.

My experience with it is that anti-fraud efforts, what you pay to run them is barely recovered by the judgments that you get in. That may be different in your experience. You seemed to indicate——

Mr. Kuriansky. Well, I think that varies from year to year. There are some years, I think, when units basically pay for themselves even in hard cash, but in most years they probably don't. Very often you are going after deadbeats or people who have left the country or in bankruptcy, and you can't always recover all the money you would like.

But I can cite to you some startling examples of the deterrent effect. In New York, for example, we investigated clinical laboratories 4 years ago. At that time, New York was spending $170 million a year on Medicaid lab payments. After we finished our investigations, today, as we sit here, New York is spending $20 million a year—from $170 million down to $20 million. We have seen the same thing in podiatry where payments dropped from $35 million to $13 million; in prescription footwear, where it dropped from $30 million to $3 million. This is in the wake of unit enforcement activity.

There is no question but that 75—80 percent of the billings were fraudulent, and when they were knocked out the State saved hundreds and hundreds of millions of dollars which they would be paying today but for those prosecutions.

Mr. McMillan. These were fraudulent in terms of services that were never performed but were billed?

Mr. Kuriansky. That is right.

Mr. McMillan. And did you critically look at services that were performed that were unneeded?

Mr. Kuriansky. Well, we look at that to some extent, but from a criminal standpoint, making a criminal case is much harder when you are dealing with medical questions of necessity. But in New York we have so many out and out thieves that we don't really have to worry about spending time on quibbling about medical diagnosis.

Mr. McMillan. That is rather extraordinary.

Mr. Smith, do you think fraud is as prevalent in Texas as it is in New York?

Mr. Smith. Well, I don't know if I can—I really don't have the knowledge to comment on that, sir, but certainly this is an area though, and I think there are two aspects, there is the fraud and investigation and there is also the customer/client protection, and these are important services for the State and also the people that are getting services.

For first dollar, most States won't put it back into those units, they will try to preserve services first, and that concerns me.

Mr. McMillan. Well, obviously with respect to reform—and we are not dealing with reform here in this budget. I wish we were. I wish we had been over a long period of time because the agonizing fact is Medicaid costs in the last 2 years have increased at the rate of 30 percent a year, and that has had a heck of an impact on the States. It is having a heck of an impact on the Federal budget.

Combined with Medicare, 60 percent of total increased spending in the Federal budget comes from those programs, and that means that it really isn't an issue. If we deal health care reform and we take in the uninsured who perhaps should be under a program like Medicaid and are not, which is a rather enormous number, then we are talking about dramatic expansions of Federal assistance if we deal with that.

The other side of the coin is, how do we fund it? We are not funding it. It is happening, and we are not funding it, we are borrowing to pay for it. So every cent that we send to the States is borrowed back from you, or perhaps some taxes are raised, but most of the taxes proposed in this budget don't go to fund Medicaid, they are essentially spent for other purposes. So we, out ahead of us, have an enormous dilemma to face up to.

I guess my question really would be, where do you see the greatest potential for greater cost effectiveness in what is going to be an expanding program, an expanding benefit group, without sacrificing quality? In other words, our ability to do things in a cost-effective manner is going to have everything to do with our ability to expand access. Do you agree with that? Are there things you think we can do that can be more cost effective?

Mr. SMITH. Certainly I believe there are. It is a little outside of, I guess, this testimony, but I think, obviously as a public health officer and my training in public health, I would have to throw in a pitch for prevention for a moment. That is everything from paying for pap smears instead of hysterectomies or paying for breast self-examination and mammography instead of radical mastectomy or paying for measles pneumonia instead of measles immunizations, which we are doing, all those things. There are some places you can begin right away.

Also, I think some of the community and home waiver issues—I think we need to get people into their homes. First of all, they would rather be there in most cases. The other is that it is less expensive in most cases. I think those are areas where you could see cost containment and savings over the long run. Right now, we are paying after the fact for more costly things that could have been prevented in the first place.

Those are two areas that I would cite.

Mr. MCMILLAN. Do you favor a managed care approach to Medicaid?

Mr. SMITH. As opposed to Medicaid the way it is currently?

Mr. MCMILLAN. Well, generally speaking, but would it be beneficial to Medicaid?

Mr. SMITH. It is often easier to package prevention and get it out of, someone used the term "medical model"—actually, I like that—as to get it into a health model where we, in fact, enforce prevention and talk about health education and outreach and some nontraditional things. Managed care allows you to package things a little differently than what we have under a traditional insurer method, which in fact traditionally pays for catastrophic——

Mr. McMillan. I understand what it is. I am talking about its application in Medicaid.

Mr. Waxman. The gentleman's time has expired.

Mr. Smith. It is a way to, in fact, package those things and is quite effective, and we are trying to model some of those right now in Texas in our Medicaid program.

Mr. McMillan. Thank you.

Mr. Waxman. Thank you, Mr. McMillan.

Mr. Kreidler.

Mr. Kreidler. Mr. Kuriansky, I would like to ask you a question in relation to the money that we provide from the Federal Government to the States for fraud control. I think the point that was made, particularly by Ms. Frank, relative to quality of care surveys and so forth is one point, and I can certainly understand it from that perspective, but from the standpoint of outright fraud, when it is so much in the States' interest that they actually make money, as you point out, why is a super match necessary from the Federal Government rather than a standard match?

Mr. Kuriansky. I think only because the States are so desperate right now. That has certainly been the case in New York. New York has been operating under such tremendous deficits, and when I talk to the budget people, they say, "We know you save us money; we know this, that, and other thing; but we've got to present a balanced budget, and you still cost $1 out of every $4 in this program; the State gives $1 out of $4; we are going to take from every State program, and we are going to take from you; you've got some State dollars; we're going to take it from you." And they just basically ignore the argument that we are cost effective, we save millions and millions of dollars. They want to see the hard cash when it comes time to balance the budget. It is foolhardy, it makes no sense whatsoever, but that is the mind of the budgeteer in the State Capitol.

Mr. Kreidler. So you really wouldn't argue that a super match is necessary from the standpoint of the State having a vested interest in making sure that we have a system that operates——

Mr. Kuriansky. The State clearly has a vested interest in this, but all I can tell you is that the only argument to which they respond at all and blood-letting finally stops is when I point out that they are getting $3 for every $1 and three State employees are paid for by the Federal Government and they only have to pay for one for this terrific program. If they find out that for every dollar they spend they are only going to get $1 back, they are going to get one more employee, it puts us in the same boat with every other program, and, you know, let the blood-letting begin.

Mr. Kreidler. Thank you very much.

Thank you, Mr. Chairman.

Mr. Waxman. Dr. Rowland.

Mr. Rowland. Mr. Chairman, I don't really have any questions of this panel, but I do have some information that I wish to provide for this subcommittee relative to Medicare and Medicaid that I would have provided had I had it yesterday, and it is relative to the number of physicians who are no longer accepting new Medicare and new Medicaid patients. So if I could make this a part of the record——

Mr. WAXMAN. Without objection, we will be very interested in receiving that for the record. [See p. 130.]

Mr. ROWLAND. Thank you, Mr. Chairman.

Mr. WAXMAN. Ms. Frank, if I could just raise a point with you. You gave us very powerful testimony about what is going to happen to nursing home residents. To me it looks like they are going to be faced with a double whammy. We are talking about reducing the matching rate to inspect the nursing homes and the matching rate for fraud unit investigations of patients abuse and patient abuse and neglect. The likely thing is, States will cut back on the patient care while they try to still do what they can to prosecute providers for fraud but not for abuse or neglect of the patients. And then yesterday we heard from Mr. Toby that the Federal agencies such as the Inspector General and HCFA's Health Standards and Quality Bureau are being cut back across the board at 3 percent. So it doesn't even appear as if the Federal Government will be stepping in to fill the holes created by the reductions in the Federal matching payments to the States for their enforcement efforts.

Taking all that together, where does this leave the elderly and disabled residents?

Ms. FRANK. We are very alarmed because we feel this is going to leave people at tremendous risk. It is very clear to us that there is not a lot of room for cutting in the budgets for efficiency's sake because the budgets have been very carefully calculated along a unit cost system, so there is no room for flex.

What is going to happen is that States will not be able to respond to consumer complaints quickly enough, and when people are starting that slow road to deterioration, if the State were able to come in quickly enough and be able to turn the situation around, people might be able to regain their strength, regain their balance, and be able to function OK. But if you wait until someone is malnourished, dehydrated, contracted, skin breakdown—has gone basically down the tubes—and then you come in for the annual survey, then you are not going to have the kind of protection that we need.

Furthermore, surveyors right now are not effective in fully applying the standards of the law. They need a lot more training, they need a lot more quality management, in their agencies, and those are the things that are going to be cut by this kind of proposal. There will be fewer surveyors going out, they will have less time to spend, they will be not as well trained as they need to be to recognize the problems. And these problems are avoidable; that is the shocking thing. It is shocking that we are paying for people to become malnourished. We are not even getting the basics of room and board in some nursing homes, we are getting not enough food, not enough water, and that is outrageous.

Mr. WAXMAN. Well, the three of you have given us very impressive testimony, and from my point of view it represents exactly the kinds of arguments that kept us from cutting back on Medicaid during the Bush administration. Wouldn't it be ironic if we made these kinds of cuts now?

Thank you very much.

Mr. LAMBERT. Mr. Chairman——

Mr. WAXMAN. We are going to have to recess to respond to a vote on the House Floor.

Mr. LAMBERT [member of audience]. OK, I'm sorry, but I'm from Mobile, Ala. I'm just a country boy, I don't have a whole lot of brains, but let me show you something, OK? This is my father right here [indicating photograph]. The answer is through enforcement. If you cut any of this, any of it at all, you are going to see this, and you are going to see it rampant, all over the United States, OK? I'm telling you that, so you all think about that.

These people are doing an excellent job. The problem is, they don't have enough people to do it. It is all over the United States, it is everywhere. This is Hill Haven Corporation, one of the biggest nursing home corporations in the United States. Look at what they did to my father. Look at what he had on, in a nursing home that you are paying your tax dollars and I'm paying mine, to wear, OK?

I want to show you this [indicating photograph]. Look at this. Do you see this? This is what we are paying for. Look at this, a bed sore. You cut enforcement, it is going to cost you more money than you could ever imagine.

Mr. WAXMAN. Mr. Lambert, you are raising in real human terms what the three people here at this table have been raising, the points they have been making to us. I appreciate that.

I am going to have to recess now, and we will be back.

Mr. LAMBERT. OK. I want you to realize the seriousness of it because I noticed, I was sitting here—this is the first time I have been to a meeting like this. There is a real need for people to be serious up there. I saw people up there giggling, talking. This is serious business. These are our people, these are our parents, and you, Mr. Waxman, are going to end up this way one day if you don't do something about it. I'm telling all of us, OK? Cut where you want, but don't cut the poor elderly people, OK? I'm sorry.

Thank you.

Mr. WAXMAN. Thank you very much.

We will now recess and reconvene in 5 or 10 minutes.

[Brief recess.]

Mr. WAXMAN. We would like to get started if you would all take your seats.

Before we begin the next panel, I do want to indicate to Mr. Lambert that his comments are going to be part of the record, and, without objection, the photos that he has submitted to the subcommittee will be received by the Chair and included in the record at the Chair's discretion, if they can be made compatible to be put into the record.

I do want to indicate to those who are present at a congressional hearing for the first time that this subcommittee does take with utmost seriousness the matters before us and that sometimes we are distracted by other conversations because so many things are going on at the very same time that we are hearing the testimony.

Furthermore, while members are not always able to be with us, we are making a record, which we will share with our colleagues in order to indicate for their consideration the wisdom of certain proposals that are being advanced to us for Medicaid cuts.

Mr. WAXMAN. Our next panel will address the administration's proposal to tighten assets rules and estate recoveries. This will be a challenge, for although the administration knows precisely how much its proposal will save over the next 5 years—$565 million—we have not details about that proposal.

All we know is that we were told yesterday that the proposal—and I quote—"provides greater assurance that individuals with substantial personal assets pay a fair share for nursing home care and certain other medical services before they qualify for Medicaid." It is hard to imagine an issue in Medicaid that is more sensitive. Once you wade through the maze of Medicaid eligibility rules and trust and estate law, the issue goes to some very fundamental questions.

Since this country has no long-term care program, should a means tested program like Medicaid be used to finance the transmission of wealth from one generation to the next? What is the responsibility of the baby boom generation to the Iwo Jima generation? And what is the responsibility of adult child to parent?

The administration argues that loopholes exist in current law, but it hasn't identified them. So we have asked the witnesses to share with us their views of what loopholes exist in current law and how those loopholes should be closed.

Brian Burwell is the division manager for Systemetrics/MEDSTAT Systems. Gerald Rohlfes is the chief of the Third Party Liability Branch of the California Department of Health Services. Vincent Russo is president of the National Academy of Elder Law Attorneys. Sheldon Goldberg is president of the American Association of Homes for the Aging. Steven Chies is the administrator of Park River Estates, a nursing facility in Coon Rapids, Minn., and appears on behalf of the American Health Care Association. Patricia Nemore is a staff attorney with the National Senior Citizens Law Center.

I would like to thank all of you for joining us today. This is a particularly complex and sensitive issue. I appreciate your willingness to step into the breach.

We are going to make each of your written statements part of the record in full. We will ask of you to limit your oral presentation to us to no more than 5 minutes, and we will have to be fairly strict about that so we can have a full opportunity to get through all the testimony today.

Why don't we start with Mr. Burwell. There is a button on the base of the mike, and we would like to hear from you.

STATEMENTS OF BRIAN O. BURWELL, DIVISION MANAGER, SYSTEMETRICS, MEDSTAT SYSTEMS, INC.; GERALD ROHLFES, CHIEF, THIRD PARTY LIABILITY BRANCH, CALIFORNIA DEPARTMENT OF HEALTH SERVICES; VINCENT J. RUSSO, PRESIDENT, NATIONAL ACADEMY OF ELDER LAW ATTORNEYS; SHELDON L. GOLDBERG, PRESIDENT, AMERICAN ASSOCIATION OF HOMES FOR THE AGING; STEVEN CHIES, ADMINISTRATOR, PARK RIVER ESTATES, ON BEHALF OF AMERICAN HEALTH CARE ASSOCIATION; AND PATRICIA NEMORE, STAFF ATTORNEY, NATIONAL SENIOR CITIZENS LAW CENTER

Mr. BURWELL. Mr. Chairman, I am very pleased not to have been asked to testify on drug formulary policy.

My name is Brian Burwell and——

Mr. WAXMAN. And they will be pleased on the next panel not to talk about your subject.

Mr. BURWELL. I am a division manager at Systemetrics, a division of MEDSTAT Systems. The reason I have been invited here is, I have done some research on the issue of Medicaid estate planning over the last few years. My first study, conducted in 1991, was for the Health Insurance Association of America, called "Middle Class Welfare: Medicaid Estate Planning for Long-Term Care Coverage." I am presently completing a second study for the Health Care Financing Administration entitled "State Responses to Medicaid Estate Planning," which describes how State Medicaid programs are trying to deal with the growth of Medicaid estate planning through new legislation, regulation, and administrative actions.

I would like to begin my testimony with a true story from the State of Wisconsin. Last year, in February 1992, an elderly man came into a local Medicaid eligibility office to make a Medicaid application on behalf of his female cousin who was a nursing home resident. His cousin was the beneficiary of an irrevocably family trust with a principal value of about $1.5 million. Although she was the trust beneficiary, the income generated from this trust was placed in a joint bank account which she and her cousin jointly held. The balance in the account was approximately $279,000.

A few days before coming to the Medicaid eligibility office, the man had made a withdrawal from the account of $184,000, leaving $95,000 left. Seeing this fund balance in the account, the eligibility worker informed the man that his cousin was not eligible for Medicaid. At that point, the man wrote himself a check on the account for $93,000, leaving a balance of $2,000. "Is she eligible now?" he asked. "Yes, she is," the eligibility worker replied.

I relate this story for two reasons. First, I want to make the point that Medicaid estate planning is not esoteric. It usually does not require the services of legal counsel and does not require extensive forethought. Funneling large sums of money through joint bank accounts is a quick and easy strategy for divesting assets without incurring Medicaid transfer of asset penalties.

Second, I want to make the point that States on their own cannot close this loophole. This type of Medicaid estate planning activity is allowed to occur due to loopholes in Federal Medicaid law, not due to State policies. New Federal legislation is needed to close this and other eligibility loopholes that allow Medicaid estate planning to occur.

Given my time constraints, I will keep my comments brief.

No one knows the exact extent of this problem or its current impact on the Medicaid program, but there is no doubt that this problem is growing and growing very rapidly. The National Academy of Elder Law Attorneys, which just formed in 1987, now numbers 2,100 members. Attorneys who specialize in the practice of Medicaid estate planning are developing an ever broadening array of techniques and are sharing these strategies very effectively with their colleagues. The growing demand for their services is evidenced by the appearance on the market of such tools as a software program for writing Medicaid trusts.

Second, although there has been considerable activity at the State level to try to close some of these loopholes, States remain constrained by Federal law and regulation. That is why there is a need for new Federal legislation to address this problem. Rather than convey to you my specific recommendations in my oral testimony, I have provided them as an attachment.

Third, I would hope that this discussion over the merits of closing Medicaid eligibility loopholes does not get caught up in a larger debate over the merits of our existing long-term care policy. Regardless of how each of us may feel about current policy, I feel that there is still an obligation for all of us to implement the policies that we have.

In my view, it is ridiculous to have a policy that allocates publicly financed long-term care benefits through a means-tested program, then have that policy be unenforceable through the existence of loopholes that allow the nonpoor to keep their wealth and still have their nursing home care paid for by the Medicaid program.

Thank you for the opportunity to present my views, and I stand ready to help the committee in addressing this problem in any way I can.

Thank you.

[Testimony resumes on p. 348.]

[The prepared statement of Mr. Burwell follows:]

STATEMENT OF BRIAN O. BURWELL

Mr. Chairman, thank you for inviting me here today to testify on the issue of Medicaid estate planning. My name is Brian Burwell, and I am a Division Manager at SysteMetrics, a division of MEDSTAT Systems, Inc. Mr. Chairman, the reason I have been invited her today is that over the last few years, I have conducted several research projects on Medicaid estate planning, and have generally tried to become informed about this Medicaid policy issue. In 1991, I conducted a study for the Health Insurance Association of America called **Middle-Class Welfare: Medicaid Estate Planning for Long-Term Care Coverage**. The study describes the range of strategies that are now being used by individuals to shelter and/or divest their assets in order to create "artificial impoverishment" and obtain Medicaid coverage for their nursing home care (ATTACHMENT 1). Second, I am just now finishing a study for the Health Care Financing Administration on **State Responses to Medicaid Estate Planning**, which describes how State Medicaid programs are addressing this policy problem through new legislation, regulation, and administrative procedures (ATTACHMENT 2).

I would like to begin my testimony with a true story from the state of Wisconsin:

> In February 1992, an elderly man came into the local Medicaid eligibility office to make a Medicaid application on behalf of his female cousin, who was in a nursing home. His cousin was the beneficiary of an irrevocable family trust with a principal value of approximately $1.5 million. Although she was the trust beneficiary, the income generated from the trust was placed in a joint bank account, which she and her cousin jointly held. The balance in the account was approximately $279,000. A few days before coming to the Medicaid eligibility office, the man had made a withdrawal of $184,000, leaving $95,000 in the account. Seeing this fund balance, the eligibility worker informed the man that his cousin was not eligible for Medicaid. At that point, the man wrote himself another check on the account for $93,000, leaving a balance of $2,000. "Is she eligible now?" he said. "Yes, she is," the eligibility worker replied.

I relate this story for two reasons. First, I want to make the point that most Medicaid estate planning is not esoteric, does not require the services of legal counsel, and does not require extensive forethought. Funnelling large sums through joint bank accounts is a quick and easy strategy for divesting assets without incurring transfer of asset penalties. Second, I want to make the point that states cannot close this gaping loophole on their own accord.

This type of Medicaid estate planning is allowed to occur due to existing **Federal** statutes governing Medicaid eligibility policy, not state policies. New **Federal** legislation is needed to close this, and other, eligibility loopholes.

Given time constraints, I will keep the rest of my comments brief.

1. No one knows the *exact* extent of Medicaid estate planning, or its impact on Medicaid expenditures, but there is no doubt that it is growing, and growing rapidly. For example, the National Academy of Elder Law Attorneys, which was only formed in 1987, now has over 2,100 members. Attorneys who specialize in the practice of Medicaid estate planning have developed an excellent communications network to share an ever-broadening array of techniques and strategies (ATTACHMENT 3). And the growing demand for their services is evidenced by the appearance on the market of such tools as a software program for writing Medicaid trusts (ATTACHMENT 4).

2. Although recently there has been considerable activity at the state level to try to close Medicaid eligibility loopholes, states remain constrained by loopholes imbedded within Federal Medicaid law and regulation. That is why there is a need for new Federal legislation to address this problem. Rather than convey my specific recommendations for new Federal legislation to you now, I have provided them in an attachment to my testimony (ATTACHMENT 5).

3. I would hope that the discussion over legislation on closing Medicaid eligibility loopholes does not get caught up in a larger debate over the merits of our existing national long-term care policy. Regardless of how each of us may feel about current policy, there is still an obligation to *implement* the policy we have. In my view, it is ridiculous to have a policy that allocates publicly-financed long-term care benefits through means-testing, but then have that policy be unenforeable through the existence of loopholes that allow the nonpoor to keep their wealth and still have their nursing home care paid for by Medicaid.

Thank you again for the opportunity to present my views to you on this policy issue. If I can be of any further assistance to this Committee in developing Federal legislation to address this problem, please feel free to call on me at any time.

Attachment 1

MIDDLE-CLASS WELFARE: MEDICAID ESTATE PLANNING FOR LONG-TERM CARE COVERAGE

Brian Burwell

SEPTEMBER 1991

SysteMetrics
A Division of MEDSTAT® Systems, Inc.
24 Hartwell Avenue
Lexington, MA 02173
617-862-1020

Copies of this report are available free of charge by calling Kipp Gabriel at 617-862-1020. After April 16, 1993, please call 617-492-9300, since we are moving our offices.

This study was conducted by SysteMetrics under contract to the Health Insurance Association of America (HIAA). The statements and opinions expressed in this paper are solely those of the author and do not necessarily reflect the opinions of HIAA.

Attachment 2

STATE RESPONSES TO MEDICAID ESTATE PLANNING

Draft Report

Brian Burwell

January 1993

SysteMetrics
A Division of MEDSTAT® Systems, Inc.
24 Hartwell Avenue
Lexington, MA 02173
617-862-1020

The final report will be available approximately mid-April 1993. For free copies, please call Kipp Gabriel at 617-492-9300 after that date.

This study was conducted by SysteMetrics for the Office of Research and Demonstrations, Health Care Financing Administration, under subcontract to Lewin-VHI of Fairfax, VA. The statements and opinions expressed in this paper are solely those of the author and do not necessarily reflect the opinions of Lewin-VHI or HCFA.

Attachment 3

1992 Institute Manual
Section #2

National
Academy of
Elder Law
Attorneys

Sophisticated Medicaid Planning & New Developments in Income Cap States: A Panel Discussion

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Second Annual
Elder Law Institute

November 13 - 15, 1992
Chicago, Illinois

Attachment 4

NEW FROM COWLES LEGAL SYSTEMS

TRUST PLUS MEDICAID™

an

Irrevocable Medicaid Trust System

for drafting irrevocable trusts to avoid
potential nursing home costs through asset divestment.

TRUST PLUS MEDICAID™ features:

- Detailed checklist for preparation of irrevocable trust and many other supporting documents (see abbreviated checklist on inside pages)
- Double-Transfer asset transfers to eliminate the fiduciary duty of the trustee to invade the trust.
- Worksheets to help determine income and gift tax ramifications plus calculation of timing and amount of gifts to be made for multiple divestment.
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- Letters of instruction to banks and brokers.
- Assignments of various types (see inside pages)
- Donor and trustee correspondence
- Itemized invoice
- Easy to learn and use
- Runs inside of WordPerfect so that editing phrases or completed documents is easy to do.
- 30 day money back guarantee

Save $200
Order before Mar. 31, 1992
$690 Special Price

REQUIREMENTS:

IBM PC compatible
WordPerfect 5.1
3 megabytes of
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COST:

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Attachment 4

TRUST PLUS MEDICAID™ CHECKLIST DESCRIPTION

Page One -	**Personal Information of Donor** (health, marriage, children, etc)
Page Two -	**Appointments** All singular/plural, masculine/feminine language is accurately modified by the system and is carried through to all supporting documents.
Pages Three, Four and Five	**Article One - Management Provisions** The following are some of the headings for which numerous phrase choices are available concerning management provisions. Trustee Appointments, Trustee(s) Accounting, Primary Co-Trustee Unavailable, Assignment of Assets to Trust, Alternate Trustee(s), Trustee Powers, Second Alternate Trustee(s), Trust Purpose, Co-Trustees' Power to Delegate, Compensation for Trustee(s), Purpose Limited to, Spendthrift Phrase, Trustee(s) Bond, Certificate of Trustee Authority and Power.
Pages Six, Seven and Eight	**Article Two - Plan of Distribution** System contains many options concerning the ultimate plan of distribution upon donor's death. Shown below is a very condensed form of the dispository provision options.

Donor's children equally. Child predeceased, to issue by representation. If no issue, to surviving children or issue by representation. Children are: [ ] Page 1 or ____________

Donor's surviving children equally. Child predeceased, to surviving children. Children are: [ ] Page 1 or

____

Donor's children equally. Child predeceased, to issue by representation in trust. If no issue, to other children or in trust for their issue. Children are: [ ] Page 1 or ________________

Given to testamentary trustee for all beneficiaries in one trust (including trust for sole named beneficiary)

Given to testamentary trustee - separate trust for each beneficiary

Pages 9 through Thirteen	**Testamentary Trust Phrases** - A testamentary trust may not be included often, but when it is this feature is a real time saver.

Trust Plus Medicaid™ allows for easy edit or insertion of phrases not included in the system. All phrase numbers chosen are kept in a data base for easy retrieval in the future if a list of all clients whose plan included a particular phrase is desirable for update or marketing purposes.

Attachment 4

Pages 14 and 15 Shown here in condensed form to show the comprehensive nature of Trust Plus Medicaid™ concerning supporting documents, form generation, correspondence, asset transfer documents, and asset transfer coordination.

Page 14 *DOCUMENTS/CORRESPONDENCE TO INCLUDE IN IRREVOCABLE TRUST PACKAGE:*

SUPPORTING DOCUMENTS MENU:
A. [X] *IRREVOCABLE FAMILY TRUST* including Trust Agreement, and Invoice
B. [ ] *SCHEDULE A ASSETS*
C. [ ] *CERTIFICATE OF TRUSTEE AUTHORITY AND POWER*

CORRESPONDENCE: **Basic information is provided, but adaptation for individual situations may be necessary.*

TO DONOR(S):
1. [ ] Initial letter describing pros, cons, and process

TO PRIMARY TRUSTEE(S):
2. [ ] Cover letter to be sent to Trustee(s) with copy of Letter #1, above

TO DESIGNATED PRIMARY TRUSTEE:
3. [ ] Follow-up letter to Trustee(s) (*giving detailed instructions on record-keeping, directions for management and reminder about filing of fiduciary income tax returns and gift tax returns - see Page 17 for divestment information*)
4. [ ] Letter for tickler file dated Jan 2nd of year following gift to remind trustee(s) to file gift tax returns.

TO OTHERS:
5. [ ] SS-4 Form with Cover Letter
[ ] Call for TAX ID Number ____________________
6. [ ] *Stockbroker SCHEDULE A asset transfer letter
7. [ ] *Bank SCHEDULE A asset transfer letter
** (Will provide instructions to institutions where accounts under Category #1 on Schedule A are held; be sure all information under Category #1 on Schedule A is complete and accurate.)*

===

Page 15 ADDITIONAL SUPPORTING DOCUMENTS MENU *(Computer-generated)*

- *Assignments on this page will create two documents; one transferring from Donor(s) to Grantor(s), and one transferring from Grantor(s) to Trustee(s) of the trust. Assignors information is requesting in whose name asset is currently titled.*
- *Documents prepared are state-generic, and may need adaption to meet specific recording requirements of your jurisdiction. However, preparation of documents by this system will provide appropriate language of documents, for easy preparation by clerical staff using your state's documents.*

A. [ ] *Business Assets Assignment* Assignors:____________________
Name of Business: ____________________
B. [ ] *Closely Held Stock Assignment* Assignors:____________________
# of Shares:__________ Corp. name:__________ President's name:__________
**Sub S election will be jeopardized.*
C. [ ] *Farm Assets Assignment* Assignors:____________________
D. [ ] *Promissory Note Assignment* Assignors:____________________
Date of Note:__________ Note is from:__________
Original $__________ [ ] Take information from attached
E. [ ] *Note and Mortgage Assignment*
Date of Mtg: __________ Date of Note:__________
From:__________ To:__________
Original $__________ [ ] Take information from attached
F. [ ] *Contract Assignment (Use in transferring interest in Contract for Deed, Deed of Trust, Land Contract, etc.)*
Grantor is: [ ] Purchaser [ ] Vendor [ ]Attached
* G. [ ] *Promissory Note* From:____________________
* H. [ ] *Mortgage* Amount:__________
* I. [ ] *Note and Mortgage Satisfaction* [ ] Full Satisfaction [ ] Partial Satisfaction ▸ $__________
J. [ ] *Quit Claim Deeds*__________
K. [ ] *Warranty Deeds*__________
L. [ ] *Bill of Sale*

* *G, H, and I above may be used when multiple divestiture in a series of months is desired to allow for transfer of real estate with n and mortgage back, and then satisfaction of note and mortgage in future months.*

Pages 16, 17, and 18 Contain notes and worksheets for determining which assets will be transferred to the trust for calculating optimum amounts to be gifted after considering exempt assets, expenses during waiting periods, monthly income, overall tax ramifications and costs of transferring assets. Data is also efficiently collected for preparation of gift tax returns at year end.

ATTACHMENT 5

Recommendations for Federal Legislation to Close Medicaid Eligibility Loopholes

1. Clarify that withdrawals of an applicants' resources from a joint bank account, even when made by non-applicants, is subject to Medicaid transfer of asset penalties. However, penalties should not be applied to withdrawals of funds orginally deposited by non-applicants.

2. Putting property into joint tenancy, even if the Medicaid applicant retains ownership rights, should be treated as an illegal transfer if the act of placing the property in joint tenancy makes the resource unavailable to the applicant.

3. The penalty period for prohibited asset transfers should begin on the day that the individual would have otherwise been eligible for Medicaid while receiving institutional care, *not* on the date of the transfer.

4. Clarify that in computing the penalty period for illegal transfers, that penalty periods for multiple transfers do not run concurrently, but consecutively. This common practice has allowed applicants to divest significant amounts of assets, yet minmize the penalty period to which they are subject.

5. There should be no time limit on the length of the penalty period, which is currently 30 months. The penalty period should equal the value of the assets transferred for less than fair market value, without limitation. However, assets transferred more than 30 months prior to Medicaid application should remain exempt from Medicaid asset transfer rules. Most states believe that "looking back" more than 30 months for illegal transfers would not be cost-effective.[1]

6. Clarify that transfers of assets made by persons acting as agents of the applicant (guardians, conservators, persons authorized to make such dispostions under a power of attorney) are treated the same as if made by the Medicaid applicant/recipient.

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[1] Some states, however, believe that the "look back" period *should* be extended more than 30 months.

ATTACHMENT 5

7. Clarify that transfers of lump sum payments, such as inheritances, that are made in the month in which they are received, are to be treated as transfers of assets, and therefore subject to penalties, and are not considered transfers of income.

8. Clarify that disclaimers of inheritances or other lump sum payments, such as court settlements, are to be treated as asset transfers, subject to penalties.

9. Limit the amount of funds that can be placed in an irrevocable funeral contract, not subject to penalties, to $1,500, or some other reasonable amount.

10. Stipulate that *any* inter vivos trust to which an applicant has transferred assets within 30 months of applying for Medicaid, regardless of whether the trust is discretionary or non-discretionary, revocable or irrevocable, is null and void, and the resources in the trust are considered immediately available to the applicant. Congress may wish to exempt, however, certain "supplemental needs" trusts created for severely disabled individuals, the income from which is used to purchase necessary equipment and/or services, not available under the regular Medicaid benefit package, for the maintenance of the disabled individual.

11. Clarify that while certain types of "income trusts" may be used as mechanisms for allowing certain individuals to qualify for Medicaid nursing home coverage in so-called "income cap" states in accordance with the Federal district court ruling in Miller vs. Ibarra, allow states to impose conditions on the creation and use of such trusts, as recently done in the state of Colorado.

12. Clarify that retroactive payments for "care" provided by relatives do not constitute "fair market value" for transferred assets. Prospective payments, however, can be made, as long as they are made under a written agreement, and the payments made represent reasonable compensation for the care or services provided.

13. Allow states to apply transfer of asset penalties to that portion of a purchased annuity that exceeds the value of the benefit that is likely to be returned to the annuitant over his or her remaining life expectancy, using life expectancy tables.

ATTACHMENT 5

14. Clarify that in the determination of the Community Spouse Resource Allowance (CSRA) under the Medicaid spousal impoverishment rules, the income of the instititutionalized spouse *must* be made available to the community spouse *prior to* determining whether the community spouse's CSRA should be increased in order to generate sufficient income to meet the Minimum Monthly Maintenance Needs Allowance (MMMNA).

15. Clarify that states may *impose* a lien on the home of a community spouse (or other exempted relative) of an institutionalized Medicaid recipient, even though states may not *foreclose* on the lien until the community spouse dies or sells the property.

16. Clarify that although term life insurance policies remain an exempt resource in most cases, certain term policies are not exempt. Specifically, resources used to purchase term life insurance policies within 30 months of Medicaid application that have a benefit-to-premium ratio in excess of certain standard would be considered available, and not exempted. For example, a term life insurance policy with a death benefit of $100,000 purchased by an 89-year-old man for the price of $97,000 would not be exempted.

Mr. WAXMAN. Thank you very much, Mr. Burwell.

Why don't we just go down the row. Mr. Rohlfes.

STATEMENT OF GERALD ROHLFES

Mr. ROHLFES. Thank you, Mr. Waxman.

My name is Gerald Rohlfes, and I am very pleased to be invited to testify before your committee, and I am pleased that my testimony has been admitted in the record, and I will not read it, but I would like to paraphrase a few of the thoughts that were in there to emphasize the importance.

First of all, in my testimony I discuss the loopholes that exist in the Federal law which allow individuals with assets to become eligible for Medicaid and still preserve the assets to transfer on to the heirs, and some of these examples that were in my testimony I thought were rather blatant examples where the benefactor of that is not the beneficiary but, rather, the heirs of the beneficiaries, and in many cases the process by which the assets transfer is conducted without knowledge of the beneficiary through a conservatorship or other arrangements.

I have been in the Medicaid program since 1966 when it was started in California, which is called Medi-cal, and I have managed a number of different programs, but I have managed the Third Party Liability Program now for the past 9 years, and we have in California the largest third party liability program of any Medicaid State in the Union, and our estate recoveries far exceed any other State. As a matter of fact, I think California's estate recoveries are probably about as large as the rest of the States combined.

That is not to say that California has been the most aggressive in this area, certainly not; Oregon has a much more aggressive program than what California has. It is largely due to the fact that California has the largest Medicaid program in the Nation.

But the point I wanted to make is that we have a staff of approximately 35 employees who work full time in the estate recovery area, and we recover about $21 million a year at a cost of about $2.5 million a year, so it is a very cost beneficial aspect.

But it is not the cost beneficial aspect that I think is really important to bring to your attention but, rather, the equity, or, better yet, the inequities that seem to exist on the part of these collectors who are administering this program in California.

The inequities relate directly to the loopholes that exist in the program and how people are able to manipulate the loopholes in such a way that they are able to avoid Medical estate recovery claims, and the people who exercise this, in the view of our collectors, are not always the most deserving, and, conversely, the claims where we do recover money are often more deserving than those where we do not, and so we feel very uncomfortable with the administration of this program despite the fact that it is a very cost beneficial program to administer. But the reason for our discomfort has to do with the fact that there is a gross lack of fairness with respect to the administration of this program, and I wanted to bring that to your attention.

I guess another fact I wanted to bring to your attention is, I also serve on the Medicaid Directors Third Party Liability, what they call a technical advisory group, or TAG group, and in that capacity

I represent other States in dealing with HCFA with respect to Federal policy in this area, and I have encounters with my counterparts from the other States as they administer this program.

One of the things I have learned is, first of all, of the 50 States that have Medicaid programs, there are only 26 that have any program whatsoever where they attempt to make recoveries against estates, and that is permissive because, the way the statute is written, there is no requirement for an estate recovery, and, as a matter of fact, the statute sounds like they don't want any estate recoveries because it starts right out by barring Medicaid agencies from making claims against correctly paid services, and then it goes on to say except, you know, in situations involving an estate and then provided then that it is only for services after 65, and then provided there is no surviving spouse and dependent, and so on and so forth. I am sure you are more familiar with that than we are.

But the tone of it, the whole tone of the Federal law, comes out very negative against State administration, and, as a consequence of that, whenever we are challenged in court on any of our claims, the interpretation of the law by the courts interprets the negative tone of that, and the burden of proof is always on the State, and, as a consequence, we have had some adverse decisions. I described that Citizens' Action League case in my testimony whereby the court held that assets held in joint tenancy are not passing through the estate and therefore not subject to State claims. The effect then of that is that anyone who has the foresight to transfer assets and put them in joint tenancy with their heirs can successfully defeat any Medicaid estate claim in California.

Let me get back to some of the other States very briefly.

Mr. WAXMAN. Well, Mr. Rohlfes, we are going to have to move on. I know 5 minutes is very, very brief, but maybe we can pick this up in questions.

Mr. ROHLFES. All right. Thank you very much.

[The prepared statement of Mr. Rohlfes follows:]

STATEMENT OF GERALD ROHLFES, CHIEF, THIRD PARTY LIABILITY BRANCH, CALIFORNIA DEPARTMENT OF HEALTH SERVICES

Good morning, my name is Gerald Rohlfes, and I am the Chief of the Third Party Liability (TPL) Branch for the California State Medicaid Agency.

It is an honor and a pleasant surprise for me to be invited to appear before your subcommittee today to speak of the need for legislation to tighten Medicaid estate recovery and transfer of asset rules. I understand that this is not only an element of president Clinton's "A Vision for Change in America" but is also a proposal endorsed by the State Medicaid Director's Association, the American Public Welfare Association, and the National Governor's Association.

I have not seen the bill language, so I will not be able to comment on specifics, but I have been the manager of the Medicaid estate recovery program in California for the past 9 years. I am also an appointed member of the State Medicaid Director's Association TPL Technical Advisory Group, so I have had experience with TPL both in and out of California.

California looks upon Medicaid estate recoveries in much the same way as we look upon other forms of TPL.That is to say, we are recovering dollars from the estates of deceased beneficiaries which are no longer needed by them or by their dependents, and using these dollars to displace dollars that would otherwise be a taxpayer obligation. In that light, we are supplementing the funding to pay for more health care needs of the poor.

California has had a Medicaid estate recovery program since 1981, and last fiscal year we recovered $21.2 million. This was recovered from 6,213 estates for an average of $3,412 from each estate claim. For the sake of comparison, this compares with other third party recoveries as follows:

[Dollars in Millions]

Casualty	$22.6
Health Insurance	6.4
Worker's Compensation	1.6

As you see, our experience indicates that estate recoveries are a significant component of alternate funding sources for Medicaid, but our administration of the program also tells us that we are collecting only a fraction of the potential. We believe changes in Federal law are needed to improve legitimate collections.

To illustrate this need let me tell you how the Federal law (42 USC section 1396p) is currently being interpreted in California. This statute generally prohibits a Medicaid State agency from recovering any medical assistance from a beneficiary that was correctly paid; except, the State may claim against the estate of a deceased beneficiary, provided that the services were received after age 65 and provided further that the beneficiary had no surviving spouse or dependent children. The word "estate" in this statute is interpreted to mean the formal probate estate. Since assets hold in joint tenancy transfer by survivorship upon the death of a tenant, and do not pass through the "estate", the State is prohibited by Federal law from claiming these assets. This means anyone with the foresight to change the ownership title of any property to include heirs as joint tenants will effectively defeat the State's authority to recover that property when they die.

When this interpretation of law was handed down (*Citizens Action League* vs. *Kizer* No. 88-15044), California was required to make over $5 million in refunds to heirs of deceased beneficiaries, and was prohibited from making any further claims on these assets. This increased our workload and reduced our recoveries.

When California appealed this interpretation, the U.S. Supreme Court recognized (No. 89-1056) that "the case was wrongly decided," but denied certiorari because the issued lacked national significance and because the court felt that "corrective legislation is also a realistic alternative."

But joint tenancy is not the only issue. There are multiple schemes available for astute heirs of Medicaid beneficiaries to protect their inheritance. Recently a Superior Court judge in Fresno brought to our attention a petition to give real property pursuant to substituted judgment. The circumstances in this case are a conservator and daughter of a Medicaid beneficiary who has been 9 years in a nursing home petitions the court to give the remainder interest in the beneficiary's home valued at $82,000 to be distributed among the adult children of the beneficiary. To protect the home as exempt property, the conservator claims the beneficiary intends to return home; and to preserve the property for that unlikely circumstance, the conservator requests that the beneficiary retain a life estate. The rationale for all of this was stated in the petition as follows:

The Conservatee will remain eligible for Medi-Cal. Without the proposed action, because the Conservatee is currently receiving Medi-Cal benefits, upon her death, Medi-Cal may seek reimbursement for amounts paid for the benefit of the Conservatee. By giving a remainder interest in her residence to her children during her life, the Conservatee will preserve the home from Medi-Cal reimbursement claims and will preserve the Conservatee's estate for her children.

In your quest to achieve Medicaid savings by tightening estate recovery and transfer of asset rules, some options to consider:

—As a minimum change 42 USC section 1396p to allow Medicaid to recover from all assets of deceased beneficiaries who have no dependents, regardless of the title of ownership in which the assets were held. Going further, rewrite this entire subsection so that its thrust is positive so as to direct Medicaid agencies to recover from estates rather than its present negative thrust of restricting such activities.

—Change 42 USC section 1396p to penalize all beneficiaries who make disqualifying asset transfers, not just institutionalized beneficiaries. Also, increase the look back period from 30 to 60 months, and make the penalties for multiple disqualifying transfers run consecutive rather than concurrent. Individuals who make disqualifying transfers should be ineligible for all Medicaid services in an amount equal to the sum of the assets they transfer.

—Change the law to allow States to claim on the estates of all beneficiaries without dependents; not just those who received services after age 65. Aged people feel the present law discriminated unfairly against them.

—Restrict trusts established by will by the courts (as in personal injury settlements) or in any way that shelter these funds specifically from being counted by

Medicaid or Public Assistance programs or from being subject to recovery of cost by the programs.

Thank you for the opportunity to offer my comments. If you have any questions, I would be happy to try answering them at this time.

Mr. WAXMAN. Thank you.

Mr. Russo.

STATEMENT OF VINCENT J. RUSSO

Mr. RUSSO. My name is Vincent Russo. I am the president of the National Academy of Elder Law Attorneys. I appreciate the opportunity to testify before your subcommittee.

I am here to share with you my experiences with seniors who are concerned that they will lose their personal dignity and independence. As an elder law attorney in the trenches with seniors in crisis, I can tell you that they are being shell-shocked into despair. Seniors have been frugal and often did without in order to build a nest egg, $100 at a time, year in and year out, decade after decade, to leave for their families so that they may have a better quality of life than their own. Just like us, seniors also believe the failed promise that Social Security and Medicaid would provide for them when they were old. Now they are the aged and the sick who need community medical care and nursing home care.

For seniors, nursing homes are always a last resort. Unfortunately, we have a health care system which discriminates against those who suffer from chronic illness. It is the health care "wheel of fortune." If it is heart attack, you are basically covered, but if it is Alzheimer's, then that is long-term care and you are in trouble. We cannot afford to continue the myth that long-term care is somehow different and less worthy of a social insurance base form of reimbursement than acute care.

The seniors I meet with are willing to pay their fair share for health care to the extent that they have the means to do so, but the current health care system for long-term care Medicaid tells middle-income Americans that they must plan impoverishment since Medicaid is a payer of last resort. They do this because it is the only rational alternative to losing their life savings.

Seniors are confronted with barriers when accessing the Medicaid program. Complexity is a problem. A client I will call James was not aware of his rights after his wife, Martha, suffered a stroke. Then he panicked, and he transferred his life savings to his daughter. He didn't know that his $60,000 was protected as a community spouse resource allowance. He simply did not know.

Documenting eligibility is a problem. Veronica desperately needed home care assistance for her husband, Arthur, so he could die at home. Veronica and Arthur depleted their resources to the point that all they had was the roof over their heads and $161 in the bank. Unable to pay for living and health care expenses, she borrowed $6,000 from her sister and soon thereafter repaid her from an inheritance of the same amount. The case worker denied Medicaid for lack of information. Arthur was finally approved for Medicaid some 5 weeks after he died and some 11 months after the initial filing.

I wish we had a fair, rational, comprehensive long-term care system in this country so there would be no need for Medicaid planning, but we do not. We should not now seek to unfairly penalize individuals who have taken legitimate actions to meet the Medicaid eligibility standards. A longer transfer penalty period will not generate a substantial savings in the Medicaid budget. The assets of most seniors are only large enough to pay privately for the average stay in a nursing home, which is approximately 28 months. The few who have greater assets will make little budgeting difference.

There is no evidence that a significant number of wealthy elderly are engaging in Medicaid planning since they have the ability to privately pay or insure long-term care. Also, the adverse tax consequences of such planning would generally outweigh the cost of care.

A longer transfer penalty period will punish seniors who are suffering from Parkinson's, Alzheimer's, senile dementia, and other debilitating diseases. To ask them to provide detailed records of all financial transactions for a 3-, 4-, or 5-year period is unconscionable, a trap guaranteeing Medicaid denial.

Look at this Medicaid application for a 2½ year period. A longer transfer penalty will not encourage seniors to purchase long-term care insurance. Those who are too old or too sick do not have the opportunity to purchase policies, and those who are too cash poor will not be able to afford the premiums, and it will be even worse with a longer penalty period.

We must resist change, such as expansion of States' rights of recovery and the voiding of trusts which, on appearance, will seem helpful but in reality will create more confusion, abuse, and injustice. Runaway health care costs are pushing States into fiscal crisis. This should not be a reason to further restrict Medicaid in the absence of realistic alternatives. Such action will only further penalize disabled seniors and make the system more unjust.

In conclusion, I am reminded of my young son, Robert, on his first trip to the Fun House. He enthusiastically entered the Fun House confident that he could find his way out. Instead, he ran into mirror after mirror until he was knocked almost unconscious. In a daze, he stumbled out. I then think of all the seniors in the health care maze, banging their heads against the mirrors of Medicaid. Please don't add any more mirrors. I hope you can find a way to take them down.

Thank you.

[The prepared statement of Mr. Russo follows:]

STATEMENT OF VINCENT J. RUSSO, PRESIDENT, NATIONAL ACADEMY OF ELDER LAW ATTORNEYS

My name is Vincent J. Russo. I am the President of the National Academy of Elder Law Attorneys and the managing partner of a New York Elder Law firm. I appreciate the opportunity to testify before your Subcommittee on the vital issue of health care reform.

The National Academy of Elder Law Attorneys (NAELA) is a professional organization that has over 2,000 members representing all fifty states. Our mission is to "ensure delivery of quality legal services for the elderly and to advocate for their interests."

I am here to share with you my experiences with seniors who are concerned that they will lose their personal dignity, independence and control over their lives. As an elder law attorney in the trenches with seniors in crisis, I can tell you that they are being shell-shocked into despair. Seniors are not merely statistics for the rationing of health care. I know them to be honest, law-abiding citizens.

Do you know these people?

Many of them immigrated to America to escape tyranny and starvation. They believe in hard work and paying dues. They had the far-sightedness to insist upon a proper education for their children. They have been frugal and often did without in order to build a nest egg -- a hundred dollars at a time, year in and year out, decade after decade - to leave for their children and grandchildren. They have a strong desire that their families have a better quality of life than their own.

Seniors also believed the promise that Social Security and Medicare would provide for them when they were old, and that America would provide for them as they provided for America. Now, they are the aged and the sick who need community medical care and nursing home care. They are the betrayed who some accuse of ripping off the system when they seek Medicaid to provide the medical care they desperately need.

They are the confused who are told to impoverish themselves; to return to the poverty they struggled so long to rise above; to abandon their dream. This we tell them is the price they must pay for long term care, but the price we demand is too high.

Seniors do not want to be sick. Nursing homes are always a last resort. Joan is in the process of placing her mentally incompetent mother in a nursing home. At a recent meeting, she shrugged her shoulders and told me that "if her mother knew what was going on, she would jump out the window."

Unfortunately, it is the "health care wheel of fortune." If it's heart attack, you're basically covered; but if it's Alzheimer's, then that's long term care and you're in trouble.

We cannot afford to continue the myth that long-term care is somehow different and less worthy of a social insurance-based form of reimbursement than acute care, or to perpetuate the injustice whereby the heart disease patient incurring great expense suffers little out-of-pocket cost while the victim of Alzheimer's Disease bears the full burden of the cost of care. The current system is grossly unfair.

The seniors I meet with are willing to pay their fair share for health care to the extent that they have the means to do so. But the current health care system for long term care (Medicaid) tells middle income Americans that they must plan impoverishment to protect their life-long savings since Medicaid is a payor of last resort. They do this planning because it is the only rational alternative to losing their life savings. Faced with losing it all, most of us would do same.

For me, planning for Medicaid eligibility is but one aspect of the larger task of my assisting clients in developing a strategy for dealing with the financial, health, and family needs of advancing years.

Dave, age 84, shared with me his feelings about implementing medicaid planning just last week - "this is depressing and unpleasant, I feel like i'm planning my funeral, but what choice do I have?" He is too old to purchase long term care insurance and is in failing mental health.

Due to the complexity of the laws, seniors without means or access to proper legal counsel also may not receive the assistance they are entitled to. A client I'll call James was not aware of his rights after his wife, Martha, suffered a stroke. Then, he panicked and transferred his life savings to his daughter. He didn't know that his $60,000 was protected as a community spouse resource allowance. His daughter subsequently gambled the savings away. Martha was subject to a 12 month penalty period and James has been unable to place her in a nursing home where she would receive appropriate care. He simply didn't know. Complexity of the law lends itself to injustice.

I wish we had a fair, rational, comprehensive long term care system in this country, so there would be no need for Medicaid planning, but we don't. In the meantime, I assist people of all ages in qualifying for those government benefits to which they are entitled by law. Seniors need to understand the transfer penalty rules just as they must understand the federal tax deductions to which they are entitled. And, as with the tax laws, different people have different planning needs, because their circumstances differ substantially.

We should not now seek to unfairly penalize "individuals who have taken legitimate actions to meet the Medicaid long-term care eligibility standards".

What will be achieved by lengthening the transfer penalty period beyond thirty months?

A longer transfer penalty period will not generate a substantial savings in the Medicaid budget. There is no evidence of the growing use of asset transfers by older persons and their families and there is no evidence that they abuse the system. Further, the average stay in a nursing home is approximately 28 months, and most seniors will have already depleted their assets by privately paying under the current thirty month penalty period.

There is no evidence that a significant number of wealthy elderly are engaging in Medicaid planning. In light of the significant adverse tax consequences from such planning coupled with the ability to privately pay or insure long term care, Medicaid planning for the wealthy is inappropriate.

A longer penalty period will result in increased administrative costs, which are already staggering. Caseworkers cannot keep up with the paperwork under current procedures, much less procedures that will add a blizzard of paperwork due to a longer penalty period.

A longer transfer penalty period will not discourage "Medicaid planning." In fact, it will likely result in an increase in desperate actions by people who have always played by the rules. Seniors will be forced further to impoverish themselves or give up control of their financial affairs in advance of catastrophic illness. This is no way to "reward" survivors of the great depression who have contributed to this country by paying taxes and fighting world wars. A longer penalty period will yield only the bleak result of further impoverishing our elders for committing the crime of leading long and productive lives.

A longer penalty period will further discriminate against those who seek assistance from a failed system. Eligible Medicaid applicants are currently being denied for "lack of information", not because they do not qualify for Medicaid.

I'll never forget Veronica, who in tears told an Administrative Law Judge at a Medicaid fair hearing, "You can keep your money, my husband will be dead before you render a decision." She desperately needed home care assistance for her dying husband, Arthur. Veronica and Arthur depleted their resources to the point at which all they had was the roof over their heads and $161 in the bank. Unable to pay for living expenses including food, housing, and medical care, she borrowed $6,000 from her sister and soon thereafter repaid her from an inheritance of the same amount. The caseworker found this unbelievable and denied Medicaid for lack of information. Medicaid was finally approved in November of 1989, some five weeks after Arthur died and some eleven months after the initial filing.

To ask seniors who are suffering from Parkinsons, Alzheimers, Senile Dementia and other debilitating diseases to provide detailed records of all financial transactions for a 3, 4 or 5 year period is unrealistic and unreasonable, a trap guaranteeing Medicaid denial. This will create more hardship and result in a more unjust system for those in need.

A longer transfer penalty period will not encourage seniors to purchase long term care insurance. Those who are too old or too sick do not have the opportunity to purchase long term care policies; and those who are too cash poor will not be able to afford the premiums. In addition, seniors who view long term care insurance as a stop-gap measure during the penalty period will be faced with increased insurance premiums if the penalty period is increased. This will render the policies even less affordable.

Those relative few who can afford the policies are no more likely to do so because of a longer penalty period than under the already long thirty month period.

Expansion of states' rights of recovery is inappropriate and must be resisted. There is already provision for recovery from the estate of a Medicaid recipient after death, but many States have poor or non-existent implementation procedures. Training the state Medicaid departments to implement improved procedures in estate recovery under existing law would be more effective than burdening already overworked staff with complex lien enforcement procedures.

We must also resist the voiding of or the expansion of recovery against trusts. Such action will penalize seniors, who rather than give it all away, have set up living trusts under the law which allows them to keep their income while protecting their assets after the passage of the penalty period.

Runaway health care costs beyond anyone's ability to manage them is pushing States into fiscal crisis. This should not be a reason to further restrict Medicaid, in the absence of realistic alternatives. Such action will only further penalize disabled seniors and make the system more unjust.

In summary, Elder Law attorneys and seniors support public policy in favor of interim positive solutions. The American long-term care crisis will not be resolved with any quick-fix approaches. The cost cutting scalpel being waved over the Medicaid program is not consistent with health care reform. We support efforts to make long term care an integral part of national health care reform. Development of a comprehensive national health care solution cannot be put off for we are in crisis now.

I am reminded of my young son, Robert, on his first trip to the funhouse. He enthusiastically entered the funhouse, confident that he could quickly find his was out. Instead, he ran into mirror after mirror until he was knocked almost unconscious. In a daze, he stumbled out. I then think of all the seniors in the health care maze, banging their heads against the mirrors of Medicaid. Please don't add any more mirrors. I hope you can find a way to take them down.

Thank you for this opportunity to testify before your Subcommittee.

Respectfully submitted,

National Academy of Elder
Law Attorneys
By
Vincent J. Russo, President

Mr. WAXMAN. Thank you, Mr. Russo.
Mr. Goldberg.

STATEMENT OF SHELDON L. GOLDBERG

Mr. GOLDBERG. Thank you very much, Mr. Chairman.

My name is Sheldon Goldberg, and it is my pleasure to appear before the subcommittee today on behalf of the American Association of Homes for the Aging. AAHA, as we call it, represents 4,600 long-term care providers and aging service providers across the country. Nursing homes, retirement communities, low-income housing, and community services are the types of services we provide, distinguishable by all being not for profit, sponsored by religious organizations of all denominations, fraternal organizations, and communities.

I want to digress for just one moment. I hope that I represent a nursing home industry that overwhelmingly are people and individuals and care givers who do not tolerate the pictures you saw earlier. They are people who give care and give it willingly and give it with tender, loving care, and so I hope that doesn't exist, and I know in much of your work that has been eradicated in this country.

I appreciate very much this opportunity to testify today. I also want to express my appreciation to you and this subcommittee because you have concerned yourself with the health of all people, especially those people who are poor, those people who are unserved, people who are elderly, frail, handicapped, disabled, women, and children.

But I have to tell you today that across this country Medicaid is in serious trouble, and it is very critical because Medicaid is the front line of health care for those who are poor and those who are indigent and those who are in need of nursing home and long-term care services. Medicaid is experiencing drastic financial problems today in State after State, and I believe, and we believe strongly that divestiture has contributed to this problem. Let me examine for just a moment what it means to a nursing home resident in terms of what is going on in the nursing homes.

First of all, there is inadequacy of reimbursement rates that are set oftentimes arbitrarily by the States. Second of all, we experience lagging payment, and, as a case in point, in the State of Illinois up to 6 to 8 months accounts receivable not being paid by the Medicaid program because of inadequate resources.

There is tremendous turmoil in the States, and you, as I know, read in the Washington Post about Tennessee deciding or exploring opting out of the Medicaid program. And the whole issue of provider tax, which we have a tremendous problem with in terms of the whole concept of being a progressive tax. We are asking the most frail individuals in our nursing homes to pay the cost for the States to come up with the match to meet the Medicaid program. What is basically happening is a tremendous sense of a perception of unfairness and inequity in the program.

Let me examine just briefly how that inequity meets the person who pays for their care, that individual who comes through and pays for his care. It hits him in four ways, the private pay resident. First of all, he has to pay for his own care. Second of all, he is subsidizing the Medicaid rate inadequacies, the shortfalls that the States do not pay the full price of care. Third, he is oftentimes, in 26 States, asked to make up a provider tax. It is not a provider tax, it is a resident tax because that is the source of the revenue, so they subsidize the State's match. Last, he or she is asked to pay for the cost of care for the person who could have afforded to pay but divested themselves of those resources.

Medicaid costs are soaring, there is no question about that, but unfortunately programs and eligibility and reimbursement are being cut, and that hurts people.

Let me digress for one moment. The issues that have come forward are, obviously, we have seen within law there is an area called elder law, and it has developed a specialty in the law in basically about how to divest assets. I have to tell you, there are books written about it, there are self-help guides, there are newspaper articles and advertisements in almost every publication, and, yes, there are even home videos, Mr. Chairman. This video [indicating exhibit] is called, "What, me pay for nursing home costs?" I share that with you in terms of videos that people can subscribe to.

I am not here to talk about the legality of divestiture, I am here to talk about the values and the ethics of the policy as best I can. When individuals divest themselves of those economic resources, it creates a higher level of burden on the system, and, as a matter of fact, it pulls resources away from those who are truly in need and those who are impoverished—women, children, families, and the frail elderly, impoverished elderly.

And it is not inconsequential, the amount of money. According to a book by Alexander Bovay—and he is the author of the book titled "The Medicaid Planning Handbook: A guide to protect your family's assets from catastrophic nursing home care"—the average cost of assets being sheltered because of divestiture ranges between $100,000 and $400,000.

Every administrator I talk to who runs a home for the aged or runs a nursing home in this country, they will have a horror story of an individual who comes in with significant financial means and very quickly divests themselves in order to become eligible for Medicaid.

We recognize that many people believe that the Government should pay for all long-term care, and that is an issue, we think, that needs to be addressed by this Congress and by this administration, but we don't believe it should be addressed by what we feel is some manipulation of the law. There needs to be a change in the notion in terms of how respond to long-term care, and the notion is that we believe very much and vehemently against the concept of divestiture.

It would be similar to a policy in this country where a middle-aged individual, such as myself, who incurred a hospital expense and was certainly eligible and could afford insurance, decided not to pay that and divested themselves to become eligible for that program. We feel very strongly that the issue is important. It takes credibility from and takes resources away from those who truly need the care.

I thank you very much for your attention. Thank you.

[Testimony resumes on p. 388.]

[The prepared statement of Mr. Goldberg follows:]

STATEMENT OF SHELDON L. GOLDBERG, PRESIDENT
AMERICAN ASSOCIATION OF HOMES FOR THE AGING
April 1, 1993

INTRODUCTION

Mr. Chairman and distinguished members of the Subcommittee on Health and the Environment, I am here today on behalf of members of the American Association of Homes for the Aging (AAHA). AAHA is the national association representing nonprofit providers of health care, housing and community-based services for the elderly. Nearly seventy-five percent of AAHA's 4,500 members are affiliated with religious organizations, while the remaining are sponsored by private foundations, fraternal organizations, government agencies, unions and community groups. Through AAHA members and the outreach programs they sponsor, we are privileged to provide services to over 1 million elderly citizens on a daily basis.

We appreciate the opportunity to testify today on an issue that has become one of the number one concerns of nursing home providers across the country. We applaud your Committee's willingness to examine the issue of Medicaid divestiture and the need to tighten transfer of assets prohibitions and estate recovery procedures. We recognize that consumers who have saved all of their lives may believe it is their right to pass on those savings to heirs. But recent studies of Medicaid estate planning practices as well as anecdotal evidence from providers suggest that the practice of Medicaid estate planning has increased dramatically since the Medicare Catastrophic Coverage Act was enacted in 1988. Furthermore, it is speculated that much of the estate planning activities are being undertaken by those in middle and upper income categories who can afford to hire elder law attorneys and financial planners to protect their assets. Such practices seriously undermine public and private sector efforts to address the long-term care dilemma.

Since 1988, a veritable cottage industry has developed among elder law attorneys who have emerged to assist families in sheltering assets for the sole purpose of Medicaid eligibility. Medicaid estate planning strategies are abundant and range from sheltering assets in trusts and to transferring assets to children. The irony is that many of these arrangements were made perfectly legal under a provision in the Medicare Catastrophic Coverage Act which modified Medicaid eligibility rules. MCCA was concerned with maintaining the community spouse in dignity if and when the other spouse entered a nursing home. AAHA supports that goal. Unfortunately the protection intended by MCCA was couched in language that encouraged divestiture for a population for whom living in modest dignity was not an issue. Elder law attorneys argue not only that their practices are legitimate and conform to the letter of the law, but also, that to fully discharge their professional responsibilities to clients, it is incumbent upon them to assist clients in divesting assets in any way that complies with the law.

Mr. Chairman, we do not question the veracity of these arguments. We do question, however, whether these practices undermine the intent of Medicaid to provide care for indigents who cannot afford to care for themselves. We also submit that such practices result in an inequitable distribution of public resources; thwart public sector attempts to meet the needs of the truly economically disadvantaged members of society; and exacerbate the serious problem of access to long-term care services by the low-income. Furthermore, such practices undermine the financial viability of long-term care providers, jeopardize their ability to provide high quality care in an increasingly costly regulatory environment and unwittingly force consumers to forgo choice in health care decision-making. Finally, consumers have little incentive to plan for their own long-term care needs in advance if they can protect their assets while receiving public benefits.

AAHA believes that Medicaid estate planning and divestiture are symptoms of a much broader problem: inadequate access to long-term care services and financial protection against catastrophic long-term care expenses. We sincerely hope that this problem is ameliorated as an integral part of national health reform. But until such reforms are enacted, we must eliminate inappropriate divestiture of assets by those who can afford to finance their own long-term care. Only by addressing this problem can we preserve scarce public resources for the needy. For every Medicaid dollar spent on someone who divested significant resources to qualify for public assistance, one less dollar is spent on the truly disadvantaged who literally have no other alternatives.

AAHA believes that the only economically viable solution to long-term care reform at this time is the establishment of a public/private partnership approach involving incentives to purchase long-term care insurance. Such an approach will rely heavily on private sector financing mechanisms which will only be effective if consumers are provided strong incentives to plan for their future long-term care needs. Loopholes in Medicaid divestiture laws provide a significant disincentive for consumers to protect themselves with private insurance mechanisms. We urge you and members of the Subcommittee on Health to seriously consider the reforms outlined below.

MEDICAID DIVESTITURE STRATEGIES

Medicaid estate planning practices assist individuals in shielding their assets from Medicaid financial eligibility requirements. The Medicare Catastrophic Coverage Act of 1988 resulted in the following changes to Medicaid rules governing divestiture:

- it required states to mandate transfer of asset restrictions;
- it extended the 24-month restriction on transfers made prior to Medicaid application to 30 months;
- it required that the resources of married couples be considered together, permitting unlimited transfers of assets between spouses; and
- it lifted the restriction on transfers for those applying for SSI or Medicaid benefits outside of an institution.

While all states have statutes that prohibit individuals from divesting their assets for the sole purpose of qualifying for Medicaid, states often are hard pressed to prove that a transfer was initiated for the sole purpose of qualifying for Medicaid. The following are some of the strategies that are employed in asset divestiture.

Loopholes in Transfer of Asset Penalty Language

The Medicare Catastrophic Coverage Act established penalty rules for transferring assets within the 30-month period of ineligibility. The law requires that "the period of ineligibility shall begin with the month in which such resources were transferred." The period of ineligibility is the lesser of 30 months or the amount of the transfer divided by the average cost of nursing home care. Assuming that the monthly cost of nursing home care is $3,000 per month, an individual with $90,000 could transfer half this amount, keep the other $45,000 to pay for nursing home care and qualify for Medicaid in just 15 months.

Another strategy is to transfer assets on a monthly basis in an amount below the cost of nursing home care in order to spend-down to Medicaid eligibility. A third method is divest assets in small sums on a gradual basis and incur concurrent periods of ineligibility. Each of these strategies represents a way to game the system and qualify for Medicaid coverage in a relatively short period of time while transferring assets in the process.

Shelter Assets through Home

Payment of debt is not considered a transfer of assets for purposes of Medicaid eligibility. Therefore, one of the easiest ways to divest assets is to use savings or liquidate assets to pay off debts such as mortgages and other loans.

Home equity represents the single greatest asset held by the elderly. It is estimated that the accumulated equity among homeowers age 65 and above is over $700 billion. The primary residence of a Medicaid beneficiary is not considered a countable asset for purposes of Medicaid eligibility. In addition to paying off the mortgage as a way to convert resources, individuals can make any number of home improvements from remodeling to additions to the home. The resources consumed by renovations are not considered a transfer of assets. In a study of Medicaid asset divestiture in the state of Massachusetts, it was discovered that one couple purchased a condominium for $165,000 and claimed it as their primary residence, thus avoiding a Medicaid penalty. This asset alone would have paid for over four years of nursing home care for one person at $40,000 per year. While it is appropriate to retain the home as long as a spouse remains in it, or until it is clear that a single individual will not return to the home, Medicaid should be able to recover its costs from a house after the death of a Medicaid beneficiary.

Other personal property also is exempt from countable assets. For example, if a car is needed for medical treatment, it is exempt, regardless of value. Some attorneys, therefore, advise their clients to buy expensive automobiles. Jewelry, clothing and home furnishings of any value also are exempt from eligibility requirements and can be purchased to shield assets and resources.

Transfer Assets

The transfer of assets is prohibited within a 30 month period of applying for Medicaid eligibility. After the 30 month period, however, these transferred assets are discounted. Accordingly, parents can transfer hundreds of thousands of dollars to children who would only be liable for payment of care for 30 months. If a parent transferred $500,000 to a child and the average cost of nursing home care was $3,000 per month, the child would only be liable for $90,000 in nursing home payments and could keep the rest.

Establish Irrevocable Trusts

Another method of divestiture is the establishment of an irrevocable trust. Under this arrangement, the trustee has access to the income generated by the trust, but not the principle. Accordingly, an individual who was earning $10,000 annually in interest payments would be required to use these funds to offset the cost of care, but the principle would be preserved for the beneficiary of the trust. In the meantime, Medicaid would make up the difference between the interest income (and other income available to the beneficiary) and the cost of care.

Establish Jointly Held Assets

Transferring assets into jointly held accounts can sometimes be an effective method for shielding assets. The effectiveness of this method is contingent upon different state laws. For example, if an individual has a joint bank account, in most states, these assets would be equally divided between those with title to the account. If a parent added a child's name to an account less than 30 months before Medicaid application, however, the assets would be deemed countable. Some states would also require the co-applicant to have actually contributed to the account — regardless of when it was established — in order to exempt half of the assets.

All assets are not treated the same by all states. For example, while some states may deem all assets in a bank account to be accessible to the applicant, stocks and bonds, real estate and other property may be treated differently. That is, all co-owners may be deemed to have equal ownership in the asset. Furthermore, states are not permitted to force individuals who hold property in joint tenancy with a Medicaid applicant to liquidate their assets and make them available to the Medicaid applicant.

DIMENSIONS OF THE PROBLEM

AAHA believes that the greatest challenge facing those who propose limiting divestiture is in documenting the extent to which individuals are scheming the Medicaid system through Medicaid estate planning practices. Unfortunately, no solid database exists to provide this information. Selected studies conducted in the 1980's however, suggest that many more people are "spending down" to Medicaid eligibility by divestiture of assets. For example, a study conducted in the State of Washington revealed that most of 700 applicants routinely denied eligibility for Medicaid eventually became eligible in two to twelve months of their original application. It was discovered that 80 percent of these individuals had sheltered their assets while only 8 percent had actually paid for services. A total of $27.5 million was sheltered from the state.

A study of this problem in Massachusetts revealed that one couple sheltered assets by purchasing a condominium for $165,000 (as I noted earlier); another purchased a diamond ring worth several thousand dollars; and a third purchased an annuity for $62,500 which was exempt since it was purchased for fair market value. While these are selected studies, evidence from nursing home administrators indicate that this problem has increased substantially in the last 18 months.

Senator Lloyd Bentsen has requested the General Accounting Office (GAO) to study the dimensions of the problem, but AAHA is concerned that the study is structured in such a way that it may not produce any further data than we already have. Mr. Chairman, even in the absence of solid documentation AAHA contends that there is evidence that Medicaid divestiture through estate planning is a growing problem. First, consider the number of books published in the past year on this topic, the increasing prevalence of seminars by financial planners, and the growth of elder law attorneys practicing in this area. Surely, so much energy would not be devoted to this practice unless it was lucrative. Second, while closing divestiture loopholes is necessary to prevent inappropriate transfers of assets, stricter enforcement of estate recovery programs must also be pursued. According to 1984 GAO study, of just 25 states surveyed, only $42 million of a possible $600 million was collected from the estate of Medicaid beneficiary due to poor enforcement.

PROVIDER CONCERNS REGARDING MEDICAID DIVESTITURE

AAHA members have expressed increasing concern regarding the Medicaid divestiture phenomenon in the past 18 months. In a survey of AAHA members conducted last fall, closing Medicaid divestiture loopholes was considered one of their top priorities.

We feel that this issue must be addressed quickly for several reasons. These reasons relate to equity concerns about the distribution of public and private resources, the need to improve access to long-term care services by the economically disadvantaged, the importance of maintaining consumer choice in the selection of long-term care services and the ability of long-term care providers to maintain fiscally sound operations which enable them to maintain high quality standards of care.

Equity Issues

Our nation faces a federal debt of $4 trillion dollars and growing. This year, it is projected that the federal deficit will exceed $300 billion dollars if nothing is done to contain the growth of spending. Entitlement programs account for 50 percent of the federal budget and a significant proportion of these dollars are spent on Medicare and Medicaid -- the two fastest growing entitlement programs in the federal budget. In 1992, the Federal government paid almost 30 percent of the nation's $809 billion health care bill and the majority of these expenditures were for Medicare and Medicaid. Between 1991 and 1992, Medicaid spending grew almost 32 percent. Under the current system, it is estimated that Medicaid spending will more than double between 1992 and 1998, from $68 billion to $146 billion.

Clearly the federal and state governments cannot continue to absorb such increases in Medicaid spending. States also are staggering under the burden of increased spending for Medicaid. Demographic and fiscal trends clearly indicate the need to address the long-term care financing crisis now. According to the Congressional Budget Office, the per capita costs of long-term care could double between 1990 and 2010 based on demographic trends, health care inflation and service intensity. The financial impact of these expenditures can be devastating. Almost 70 percent of women — those at greatest risk for long-term care expenses — with assets of between $10,000 and $25,000 at age 65 will incur out-of-pocket expenses in excess of their assets. Clearly precious resources must be conserved to care for such vulnerable members of society.

Part of the solution must be assuring that scarce public resources are preserved for the truly needy. AAHA contends that those individuals who have the resources to finance their own long-term care needs should be required to do so. The loopholes in Medicaid divestiture laws result in the well-off using taxpayer dollars to protect their inheritance, which jeopardizes the ability of the low-income to obtain the services they need.

Medicaid shortfalls resulting from divestiture loopholes also result in cost-shifting to private pay residents. When state Medicaid payments to providers are inadequate to cover the costs of care, providers are forced to increase costs to private pay residents to make up for the Medicaid shortfall. It isn't fair for those who have planned for their long-term care expenses to absorb the costs of care for individuals who can afford to pay for their own care and who would be financing their own services but for divestiture loopholes.

Financial Stability of Nursing Homes

Historically, Medicaid has paid for almost half of all nursing home care. Payments for care more often have been based on state budget constraints, rather than on the costs to facilities of providing high quality care to Medicaid beneficiaries. Inadequate payments have been exacerbated by federally-mandated program requirements, such as the nursing home reform provisions of OBRA 1987 and 1990; the Americans with Disabilities Act; the Patient Self-Determination Act; OSHA's requirements for blood-borne pathogens; and numerous other federal regulations with which facilities must comply to qualify for federal and state payments.

AAHA strongly supports high quality of care in nursing facilities. There has been little recognition, however, by the Medicare and Medicaid programs of the costs imposed by federal mandates.

Mr. Chairman, as nonprofit providers, our members are committed to serving the needs of the elderly in their communities and providing high quality care. Medicaid divestiture loopholes frustrate their ability to meet these goals by placing additional and needless strain on Medicaid budgets which perpetuates, if not worsens, the Medicaid payment and access problems.

Long Term Care System Reform

Issues such as divestiture, estate planning and provider taxes and donations all result in a Medicaid system gone astray. AAHA has testified before the Administration's Health Reform Task Force regarding the need for a long-term care system that relies on public and private partnerships, with back-end catastrophic coverage and incentives for individuals to take responsibility for paying for their care, if possible. AAHA believes that the dollars available for long-term care are scarce, and should be allocated primarily to individuals who cannot otherwise pay for health care services. A copy of our plan, "Partnership in Caring", is attached to our testimony.

While the potential of long-term care insurance to finance long-term care is debated, there is no debate that consumers will have little reason to purchase insurance if they can legally protect their assets while still qualifying for Medicaid.

A major deterrent to the viability of the private market is lack of clarity regarding public and private sector responsibilities to insure long-term care risk. An important reason for purchasing private long-term care insurance is asset protection. Even a two year nursing home policy would provide adequate coverage for most people who enter a nursing home. But consumers have little incentive to purchase private insurance coverage if they can qualify for Medicaid after divesting their assets. Medicaid divestiture loopholes provide a significant disincentive against the purchase of long-term care insurance for the population most at risk of spending down to Medicaid. Closing these loopholes would provide an incentive for purchasing insurance and reduce pressure on increasingly strained Medicaid budgets.

RECOMMENDATIONS

Mr. Chairman, AAHA will be pleased to work with you on resolving these problems. We have a number of recommendations which we believe will preserve scarce medicaid resources for those who need them most.

1. The lookback period of 30 months should be extended to 5 years.

2. States should be required to implement aggressive estate recovery programs. Although State recovery laws often exists, States have not usually enforced such laws. Recovery programs would recoup Medicaid payments from the estates of Medicaid beneficiaries before the proceeds were distributed to heirs. To protect surviving dependents, states should be prohibited from recovering assets until assets are no longer needed by the last surviving dependent.

3. Property liens should be mandated as a condition of Medicaid eligibility to secure property owned by applicants for later recovery. Furthermore, liens should remain in effect until benefit payments are recovered--even if Medicaid benefits have been discontinued prior to the death of the Medicaid beneficiary.

4. Federal law should prohibit the sheltering of assets in Medicaid trusts, annuities and other such financial instruments.

5. Federal law should require interstate enforcement of Medicaid eligibility rules to avoid situations in which an individual may hold assets in one state and qualify for Medicaid benefits in another state.

6. Medicaid transfer of asset rules should be extended to anyone collecting Medicaid benefits for long-term care services, regardless of setting, not just to those who receive benefits for institutional care.

7. There should be restrictions against concurrent periods of ineligibility, so that individuals cannot gradually divest assets in small lump sums, run concurrent periods of ineligibility for each divestment, and qualify for Medicaid benefits in far less than 30 months.

8. Providers should be allowed to continue to gather financial information on prospective residents. As noted earlier, one of the most difficult aspects of addressing the Medicaid divestiture problem is the ability to document the extent to which these practices occur.

   Nursing facilities can play an important role in monitoring inappropriate divestiture of funds to qualify for Medicaid. Nursing facilities currently request certain financial information from non-Medicaid individuals who are entering a facility. In the course of gathering that information, facilities often learn of assets that have been recently transferred in order to qualify for Medicaid, and the nursing facilities are able to inform the State Medicaid agency. The Health Care Financing Administration is currently considering a policy to restrict nursing facilities from gathering such information.

   AAHA believes that such restriction, which would be unprecedented among health care providers, would not only cripple facilities in managing their financial operations, but would also eliminate one of the few methods for monitoring transfers of assets in order to qualify for Medicaid. Additional reasons for allowing nursing facilities to inquire about financial status may be found in the attached letter to the Health Care Financing Administration.

ENHANCED ADMINISTRATIVE MATCHING FUNDS

I would like to briefly touch upon a second issue of concern to AAHA, that of enhanced Medicaid Matching Funds.

The Administration is proposing to reduce all Medicaid administrative matching funds to 50 percent, including the current enhanced matching funds for implementation of key portions of the nursing home reform provisions of OBRA 1987. Matching rates of 80 per cent for OBRA survey and certification activities in FY 1993, and 75 per cent thereafter, as well as the 75 per cent matching for Preadmission Screening and Annual Resident Review (PASARR) would be reduced to 50 per cent, thereby disadvantaging States in their efforts to monitor and improve the quality of care in nursing facilities.

AAHA has serious concerns about the impact of such reductions on implementation of nursing facility reforms.

In justifying these reductions, the Administration asserts that States have already had several years to implement these changes. Regarding nursing facility reforms, that simply is not true. In fact, the full regulatory structure for OBRA 1987 has yet to be promulgated, let alone implemented. Key regulations have been trickling out of the Health Care Financing Administration (HCFA) over several years. None of the final regulations to implement OBRA nursing facility reform provisions were effective before April 1, 1992. Two major regulations, for resident assessment and survey, certification and enforcement, have only recently been published in proposed form, and it is likely to be a year or more before those regulations are final. A chart of the status of key regulations affecting nursing facilities is attached to our testimony.

The two major regulations which have not yet been published in final form (resident assessment and survey and enforcement) comprise much of the heart of OBRA nursing facility reform, and both will require extensive training and implementation costs. Enhanced Medicaid matching funds are needed to provide the incentive and ability to implement the new regulations in a timely and efficient manner. Given the staggered rate at which the final regulations are being promulgated, and the resulting modifications needed to integrate the various regulations into a cohesive survey and enforcement process, enhanced matching funds should remain in effect for at least 2 years after the effective date of the final OBRA regulation to be promulgated.

In our experience, states are most likely to compensate for reduced Medicaid matching funds by reducing survey staff, not filling vacant survey staff positions, not conducting standard or extended surveys on a timely basis, and possibly implementing heavy provider taxes or licensure fees. All of these options are likely to undermine the quality of care improvements intended by OBRA 1987.

While we do not believe there is a large amount of fat and waste in the survey and certification requirements, we do recommend a number of changes to eliminate duplication of effort and reduce inefficient and unnecessary paperwork in the survey process.

A critical improvement could be made by eliminating the duplication of effort required for two annual resident reviews to be performed each year on each resident with mental illness or mental retardation. AAHA recommends that the review required under Preadmission Screening and Annual Resident Review (PASARR) for mentally ill or retarded residents be combined with the review required for all nursing facility residents. We have attached a proposal to accomplish this streamlining and reduce duplication of effort to our testimony.

While we strongly support the intent of OBRA nursing facility reform to shift the focus of the survey process from one of paper compliance to actual resident care, we must observe that OBRA did not eliminate the many process-oriented requirements currently in place; rather OBRA simply added outcome indicators and expectations on top of them. Under the current survey system designed by HCFA, surveyors presently have to complete over 200 forms for each nursing facility survey. In the experience of our members, when surveyors are constrained by limited time or resources, they are often overwhelmed by the massive documentation required, and become so focused on meeting the paperwork requirements that the outcome-oriented aspects of the survey are limited or ignored. We believe this survey mode flies in the face of the intent of OBRA to improve quality by focusing on actual resident care and outcomes, and such surveys will be much more frequent if the Medicaid enhanced matching funds for OBRA are eliminated.

We recommend that Congress retain the enhanced Medicaid matching funds for at least two years following implementation of the final OBRA nursing facility regulation, and direct HCFA to streamline survey and certification process requirements and paperwork, in order to more effectively focus on actual resident well-being.

CONCLUSION

Mr. Chairman, AAHA clearly advocates the need to close Medicaid divestiture loopholes and strengthen state enforcement of estate recovery programs to ensure that public funding is preserved for the truly needy. We also believe that Medicaid estate planning practices are symptoms of a much larger problem--the need for reform of our nation's long-term care system. In the absence of adequate financial protection against long-term care risk, consumers will continue to be forced to obtain protection against catastrophic long-term care expenses as best they can.

We look forward to working with you and your staff to reform our nation's long-term care system and to provide high quality long-term care services to all individuals who need it. Thank you for the opportunity to present our views on this important issue.

A Partnership in Caring:

The AAHA Long-Term Care Reform Plan

Introduction

Today, our nation is in crisis and our citizens at a crossroads over one of the most complex and emotional issues of our time — health care reform. Despite the fact that we spend more per capita for health care than any other nation in the world, nearly 37 million Americans remain without the basic protection of health insurance.

And that's only half the problem.

There are an additional 32 million older adults at risk today because they have no protection against the staggering costs of long-term care.

Long-term care is not something that can be ignored. A 65-year-old has a 43 percent chance of entering a nursing home and an even greater likelihood of becoming disabled in the community and requiring supportive services.

The costs of these services can easily bankrupt the typical American. Three days a week of home care can start at $10,000 a year. Nursing home care averages $36,000 a year and can easily run twice as high. Most Americans are left to pay for these costs out of their own pockets. Nationally, Medicare and private insurance pay for only about three percent of the long-term care bill; half is paid for directly out-of-pocket by the elderly and their families, and the rest is financed through public assistance under the federal/state Medicaid program.

In the end, most older Americans are left with one option: impoverishment in return for care.

The American Association of Homes for the Aging (AAHA) believes this so-called "system" of long-term care is a far cry from what we need and deserve as a nation. As not-for-profit providers of health and housing services for the elderly, AAHA members are committed to finding a more rational, humane and effective way to care for our citizens.

The truth is, we have not only a moral but a demographic imperative to face this problem now. Those over 65 represent the fastest-growing segment of our population. The number of individuals over 85 — half of whom need assistance with daily activities — is growing even more rapidly. And the needs of the aging baby boomers are right around the corner.

Some say we cannot afford to simultaneously address health and long-term care reform because long-term care is too costly. We believe we can't afford *not* to include long-term care. Only by addressing both problems will we be able to care for our citizens *and* effectively tackle our country's staggering national debt.

Given the magnitude of the long-term care needs and costs facing our nation, we think the only viable solution is through a strong partnership between the public and private sectors. We believe that everyone in our society — individuals, business and government — has an obligation and an opportunity to help solve this dilemma.

That's why AAHA has developed a cooperative solution to the long-term care crisis. The AAHA Long-Term Care Reform Plan is based on the principle that individuals who can afford to protect themselves against the risk of long-term care should be given strong incentives to do so, while scarce public resources are preserved for those most in need. Our plan protects all Americans against catastrophic long-term care costs and covers a range of services to help individuals stay as independent as possible for as long as possible.

Our plan is not a panacea, but it is a fair and effective start to ensuring that all of us spend our last years cared for in an affordable, quality environment. We invite you to learn more about our solution to the long-term care crisis and join us in calling for action on this critical issue.

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The AAHA Long-Term Care Reform Plan

Our plan is based on a set of principles that we believe are essential to ensuring universal access to long-term care services, consumer choice and cost control. Each element of the program — covered services, eligibility, financing and cost control — springs directly from these principles.

What services are covered?

We believe that both government and private insurance should cover the full range of long-term care services available today. This is the only way to promote the use of cost-effective services while ensuring that consumers retain their right to choose their own care. Our plan offers public and private coverage of care provided in settings from independent senior housing and residential facilities to nursing homes, private homes and the community.

Under the AAHA plan, long-term nursing home stays representing catastrophic costs would be covered through a new government insurance program. Shorter-term nursing home stays and supportive services would be covered through personal resources and private insurance for those who can afford it. Public assistance would continue to be provided for the needy and would no longer be limited to institutional care.

Our plan would require payment for supportive services in any setting. This would give individuals access to health-related services in the least restrictive environment possible, allowing them to maintain their independence as long as they can. For example, our plan encourages the development of independent senior housing facilities that offer supportive services to help an older person live independently instead of in a nursing home.

Federal programs such as the Congregate Housing Services Program and the Social Health Maintenance Organization demonstration have shown that alternate care arrangements can result in significant cost savings. By paying for all types of long-term care services, the AAHA plan would expand access to care while holding the line on costs.

We also believe that both government programs and private insurance should help families and friends who act as caregivers to those in need. That's why our plan covers access to a wide range of supportive services and provides incentives to promote this kind of informal caregiving.

Who is eligible for coverage?

Under our proposal, everyone would be eligible for catastrophic nursing home benefits, regardless of age or income. Public assistance for institutional and community-based care would be provided to those who cannot afford or qualify for private insurance.

Eligibility for benefits would be based on a uniform measure of impairment in functional and cognitive skills. The use of these types of measurements can help control costs and reduce barriers to care, particularly for special populations such as individuals with Alzheimer's disease.

Who pays for this coverage?

AAHA has long supported public-private partnerships to solve the nation's health care problems. Our long-term care plan is no different. We believe that those with the economic means to pay for their own care should do so and the government should fund care for the most needy. The most needy are defined as those who cannot afford even short-term care and those who incur catastrophic expenses for long-term care.

AAHA's plan asks all sectors in our society to do their part:

Public Sector Role

Under our package, a new federal insurance program would cover catastrophic nursing home expenses — those incurred after the first 12 to 24 months in a nursing home. Individuals would be asked to pay for this initial deductible period and for supportive services through their own income, private long-term care insurance, tax-free savings accounts earmarked for long-term care, home equity conversion loans or other savings or investment vehicles. Those who cannot afford these cost-sharing requirements would be eligible for public assistance.

Public benefits for the nursing home deductible would continue to be paid by Medicaid under the current program structure. Assistance for supportive services would be available on a sliding-scale basis according to ability to pay. People in the lowest income categories would receive full benefits with no cost-sharing responsibilities beyond those already required under Medicaid. This aid could be used to pay for supportive services such as care provided in the home, in central locations in the community or within senior residential environments such as independent housing and assisted living facilities. The housing portion of residential care for the needy would continue to be financed through other programs such as government rent subsidies and Supplemental Security Income.

Limiting exposure to less costly long-term care expenses such as an initial nursing home deductible and supportive services would make private insurance much less expensive and, therefore, would encourage more people to purchase coverage. For example, the average buyer could purchase a two-year nursing home policy for an annual premium of about $700. A policy covering two years each of nursing home and home care services would cost about $1,000. These costs are about the same as those for Medicare supplemental insurance policies, which 70 percent of the over-65 population now own. Furthermore, this coverage could be integrated with Medicare supplemental insurance benefits to further reduce the costs of marketing and administering private long-term care policies.

Tax Incentives

To further help those who can pay for their own care, we recommend government tax incentives for individuals who buy private long-term care insurance, establish long-term care savings accounts or assist in financing the long-term care needs of elderly relatives or dependents.

Medicaid Reform

AAHA's plan also calls on the government to close loopholes that deplete scarce public resources in the Medicaid program. Our package prohibits individuals from transferring assets for the sole purpose of qualifying for Medicaid benefits. However, we would allow people to keep a higher level of assets ($30,000 for individuals and $60,000 for couples), so they will not be forced to impoverish themselves before qualifying for government assistance.

The Medicaid program also would be changed to offer incentives for people to purchase long-term care insurance. For example, those who buy a policy providing at least two to three years of nursing home coverage would have all of their assets exempt from Medicaid requirements if their nursing home stay exceeded their insurance benefits. However, we would require individuals to use the income generated from these protected assets to help offset the cost of services financed under the new federal insurance program.

Private Sector Role

AAHA's plan retains a significant role for the private market in promoting coverage of long-term care services.

Our proposal calls on insurance companies to provide consumers with a wide range of long-term care insurance policies that offer high value at a reasonable price. We support the enactment of federal minimum standards for such insurance to guarantee greater uniformity among products and to protect consumers. We also ask the IRS to clarify the tax status of long-term care insurance premiums and benefits.

Until it does, individuals and employers will not know whether tax-free contributions can be made for premiums or whether benefits will be taxed at the time of payment.

Under our plan, banks and lenders would play a greater role in helping the elderly pay for long-term care services by offering expanded options for tapping their single-greatest asset — the equity in their homes. It's estimated that the accumulated equity represented by homeowners over age 65 is between $700 billion and $1 trillion. Our plan calls for the greater use of such options as the reverse mortgage.

We also would ask employers to recognize their responsibility to help educate their employees about long-term care risk and options for obtaining protection. Our plan would encourage more employers to offer private long-term care insurance benefits (employer or employee-paid) and employee assistance programs ranging from information and referral to retirement planning.

How are costs contained?

The viability of any long-term care reform proposal is contingent upon adequate payment for care. Historically, Medicaid has paid for almost half of all nursing home care. Payments to providers, however, most often have been based on state budget needs, not the true costs of providing high quality care and complying with increasingly complex regulations. AAHA strongly believes that public reimbursement must accurately reflect the cost of services, including regulatory compliance.

At the same time, we believe the nation's long-term care system must promote cost-conscious behavior on the part of consumers, health care providers and regulators. That's why our plan calls for:

- Developing managed care systems to promote the most appropriate and cost-effective mix of services.
- Streamlining administrative and regulatory costs and reinvesting these savings into expanded coverage of long-term care services.
- Improving planning and coordination of federal, state and local resources to promote access and cost-effective service delivery.
- Enhancing the coordination of acute and long-term care service delivery.

Under managed care systems, a single provider is responsible for following the total health care needs of a patient and providing that individual the most appropriate and cost-effective mix of services to meet his or her needs. Care management strategies will help consumers get the best quality care at the lowest cost.

A Call to Action

Clearly, we have no time to lose in addressing this critical issue. To meet the needs of a rapidly increasing older population, we must act now. We believe the best solution to the long-term care crisis is a public-private partnership in which individuals with the financial ability to fund their own long-term care needs are provided strong incentives to do so, while scarce public resources are preserved for those most in need.

Only through partnership can we effect the kind of change our nation needs. Together, we can work to create a true "system" of long-term care that gives our parents, grandparents and ourselves, the kind of affordable, quality care we deserve.

Add your voice to ours in calling for a solution to the nation's long-term care crisis. Our futures depend on it.

The American Association of Homes for the Aging is the national association of not-for-profit organizations dedicated to providing quality housing, health, community and related services to the elderly. AAHA's mission is to represent and promote the common interests of its members through leadership, advocacy, education and other services in order to enhance members' ability to serve their constituencies.

A A H A

AMERICAN ASSOCIATION OF HOMES FOR THE AGING
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November 17, 1992

Ms. Christine Nye, Director
Medicaid Bureau
Health Care Financing Administration
200 East High Rise Building
6325 Security Boulevard
Baltimore, MD 21207

Dear Ms. Nye:

I am writing with respect to an issue of national policy concerning the ability of free-standing nursing facilities to obtain financial information from prospective residents. We believe that this problem is of such magnitude that an adverse determination will threaten the viability of providers who now serve more than 1.5 million nursing home residents with limited means.

The issue arose in the context of complaints lodged against two Michigan nursing homes for practices related to their purported use of resident financial information. Attached are copies of correspondence to Richard Yerian, D.O., Chief Medical Consultant, Bureau of Health Systems, Michigan Department of Public Health from Walter V. Kummer, Associate Regional Administrator [DHHS Region 5], Division of Health Standards and Quality; the Sisters of Bon Secours Nursing Care Center in St. Clair, Michigan; and Oakbrook Common Health Center, Dearborn, Michigan, that detail the specifics of those cases.

Because there appears to be a dispute about the facts in the two cases, our Association is not expressing an opinion or taking a position on whether a deficiency citation was appropriate in the specific cases. It appears to us, however, that Mr. Kummer's response could be construed to prohibit the collection of any financial information from residents prior to admission. We believe Mr. Kummer's position is not supported by statute or regulation; therefore, we are seeking clarification from HCFA's central office on this issue.

Mr. Kummer's thesis is a facility's request for financial information of prospective residents is a de facto method of inducing potential residents to waive their eligibility for Medicaid. We believe that this interpretation is without merit.

Representing not-for-profit organizations dedicated to providing quality health care, housing and services to the nation's elderly

CATHERINE R. PRICE, RHP, *CHAIR* SHELDON L. GOLDBERG, *PRESIDENT*

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In support of his position, Mr. Kummer cites statutory provisions which prohibit providers from requiring residents to waive their rights to Medicare or Medicaid benefits or require oral or written assurance that such individuals are not eligible for, or will not apply for, these benefits. Sections 1819(c)(5)(A)(i)(1), and 1919 (c)(5)(A)(i)(1) of the Social Security Act (SSA) [codified at 42 CFR 483.12(d)(1)(ii)]; surveyor instructions appearing at State Operations Manual (SOM) page P-73, tag number F211. He incorrectly argues, however, that the common practice of a nursing home requiring financial information from the prospective resident at the time of admission violates this requirement per se.

The relevant provisions of the statute and regulations attack discrimination against Medicaid or Medicare patients by prohibiting activities of providers designed to extract a promise from a prospective resident that he or she is not eligible, or will not apply, for Medicare or Medicaid benefits. As will be discussed below, there are many important and legitimate reasons why a facility needs to collect financial information on residents it admits. While it is true that a facility which wishes to violate the statutory mandates and discriminate against admission of Medicaid or Medicare patients could use such information to further that end, the request of information from all prospective residents cannot in and of itself be considered, under any common sense approach, a violation of the statutory prohibition against discrimination.

In reaching his conclusion, Mr. Kummer overlooks several unquestionably permissible and necessary uses of such financial data.

1. Resident financial information substitutes for information routinely collected by other health care providers. Other health care providers that participate in Medicare and Medicaid (physicians, hospitals, home health agencies, hospices, etc.) routinely gather information about patients' ability to pay by requiring proof of insurance (including Medicaid-eligibility and availability of Medicare benefits) or other payment source. They are not required to rely on a patient's representation that insurance or other payment sources exist. Nursing facilities should be accorded the same opportunities. This is no more than good business practice.

Unfortunately, the lack of insurance coverage for nursing home care on the part of most residents deprives facilities of this well-accepted avenue of determining ability to pay. It is also common that prospective residents seek admission to nursing homes before Medicaid eligibility is established. The only means available for nursing facilities to obtain the same information as other providers are entitled to is to ask for a resident's financial information. No other business or enterprise is required to provide services to a potentially unlimited client or customer population, without any assurance of any payment, as nursing facilities would be required to do if Mr. Kummer's opinion prevails.

2. Financial data can be used to advise residents of Medicaid eligibility. Mr. Kummer fails to consider the fact that facilities use financial information to inform residents of their eligibility for Medicaid benefits. Section 1919(c)(5)(A)(III) of the SSA requires facilities to provide written and oral information about how to apply for and use Medicaid and Medicaid benefits and how to receive refunds for previous payments covered by such benefits. The regulation implementing this provision, found at 42 CFR 483.10(b)(5)(i), is even more specific:

> (5) The facility must--
> (i) Inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility, or when the resident becomes eligible for Medicaid of--[items, services, and charges included and not included in the state plan...] [emphasis added].

This statutory obligation to advise residents is meaningless if provided outside the context of the resident's financial information. Even where family members are available and willing to apply for Medicaid on a resident's behalf, the family must frequently rely on nursing facility staff to explain the eligibility implications of a resident's personal finances and assist with application for benefits. More often than not, however, it is the social worker or other nursing facility staff who undertakes the task of applying for Medicaid on a resident's behalf. Without having access to a resident's personal information, this task is impossible.

In addition, resident financial information reduces the possibility of "mistakes" about Medicaid eligibility. It is not uncommon for residents to seek admission to nursing facilities while their Medicaid-eligible status is pending. It is also common for prospective residents to believe they are eligible for Medicaid, although they have not yet applied for benefits.

The risk for providers is that residents may be incorrect in their belief that they are eligible for Title XIX. In some states, Medicaid agencies have up to 60 days to make an eligibility determination. If at the end of the 60 days, the resident is found ineligible, the facility must keep the resident for another 30 days to meet the notice requirements under OBRA's transfer provisions. Under this scenario, facilities can bear the cost for 90 days of care or more.

Mr. Kummer cites regulation 42 CFR 483.12(d)(1)(ii) (pertaining to the prohibition against requiring residents to waive Medicare/Medicaid benefits) as authority to prohibiting facilities from applying a "means test ...for assurance that the applicant is not eligible for Medicaid and will not be for some time...." (Kummer letter, page 2, paragraph 3). This reading appears to be inconsistent with HCFA's interpretive guideline that accompanies 42 CFR 493.12(d)(2) (pertaining to the prohibition against third party guarantors). That guideline states as follows:

> "The facility may not require a third person to accept personal responsibility for paying the facility bill out of his or her own funds; however, he or she may use the resident's money to pay for care. A third party guarantee is not the same as a third party payor, e.g., an insurance company; and this provision does not preclude the facility from obtaining information about Medicare or Medicaid eligibility or the availability of private insurance. The prohibition against third party guarantees applied to all residents and prospective residents in all certified long-term care facilities, regardless of payment source. Notwithstanding the above, this provision does not prohibit a third party from voluntarily making payment on behalf of a resident. [Emphasis added.]

It strains reason to assume that HCFA would issue a guideline explicitly allowing inquiry into Medicaid eligibility if it thought that another section of the same rule prohibited that practice. Mr. Kummer has developed an unwritten, ad hoc interpretation of 42 CFR 483.12(d) that runs contrary to the agency's written interpretation of the same rule.

Until HCFA and state Medicaid agencies develop some system of presumptive eligibility or prior authorization for individuals whose Medicaid eligibility is pending or unclear, facilities must have financial data available on which to make at least an "educated guess" with respect to eligibility.

3. Resident financial information will reveal sources of resident income needed to contribute to Medicaid's share of the rate. In states with programs for "Medically needy" persons," the income of eligible persons (except for deductions) must be used to reduce the Medicaid program's payment for the individual's care in a nursing home or other medical institution. A facility uses a resident's financial information to identify those sources for which the facility can arrange to have the contribution sent directly to the facility as payee. This not only assures that the provider has a more predictable payment source but also relieves the resident of having to be concerned about the monthly payment. In that many residents find it difficult to handle accounting demands, this can be a real service. Residents always have the option, of course, of refusing to make a facility the payee.

4. Resident financial information assists in facility budgeting. All of our member homes are not-for-profit, and most subsidize resident care costs

from various sources. Even our members who admit residents without any regard to payment source require financial information to estimate when residents will become Medicaid-eligible (if they are not eligible at the time of admission) in order to plan how and when subsidies for costs not covered by Medicaid must be allocated. Subsidies must be managed at least as carefully as other revenue sources. Requiring financial information for budget forecasting of projected income is a sound and acceptable means of financial planning, particularly if facilities are to continue operations that are efficient enough to survive under current reimbursement formulas.

5. Financial information is necessary to identify residents who do not meet the definition of "Categorically Needy" under the state Medicaid program. According to HCFA data, 41 state Medicaid programs now have a medically needy program for residents over 65 whose income is too high to qualify for Medicaid but too low to cover the costs of nursing home care. It is our understanding, however, that a number of states, e.g., Maryland and Washington, are considering elimination of the medically needy program to reduce Medicaid costs. If this becomes a trend, nursing facilities will be faced with increasing numbers of applicants who have no way to pay for more than a portion of their care. In these cases, Mr. Kummer's suggestion that facilities simply ask residents if they are Medicaid-eligible will not provide useful information to the facility, because the implication that individuals who are not Medicaid-eligible will automatically be able to pay privately will not be well-founded. Facilities will need financial information to evaluate the portion of fees a resident can afford before the facility can determine what kind of subsidy will be required, if, indeed, the facility is in a position to provide any subsidy at all.

6. A resident's personal financial information may determine whether the facility has a bed available. Mr. Kummer correctly notes that Medicaid certification of less than all of a facility's beds is legal. Although state statutes requiring full certification have been advocated by some, the fact remains that constraints on state and federal Medicaid dollars make full certification unmanageable at both government and facility levels.

Mr. Kummer argues that a resident's financial information can be used by facilities to reject Medicaid residents so that facilities can place private pay residents in Medicaid-certified beds, thus denying access to residents who rely on public payment sources.

We acknowledge that this is a possible use of resident financial statements; however, it is much more often the case that the facility simply does not have a Medicaid bed available. It is also true that states will not pay for care given to a Medicaid resident in a bed that is not certified.

This combination of facts leaves facilities in a very tenuous position. They can require that financial information be provided and use it to refer individuals to facilities that have beds available for Medicaid residents (thus opening themselves to allegations of discrimination) or they can accept the resident's word that private resources will be used to pay for a bed and then deal with the consequences if the resident has made a mistake about his or her ability to pay. Even if this resident can subsequently qualify for Medicaid, the state will not pay for the care in a noncertified bed. In some nursing homes, this can only lead to transfer for nonpayment, resulting in needless trauma for the resident. If the error is not apparent before the resident has been in the facility for 30 days, the facility must provide an additional 30 days notice to the resident before transfer, thus exposing the provider to 60 days of care costs, with no compensation. For not-for-profit nursing facilities, preservation of their tax-exempt status arguably requires that the resident not be discharged at all for lack of payment. This potential financial liability for an unlimited number of Medicaid residents, or residents who have virtually no means of paying for services, is simply inappropriate, particularly when another facility with a Medicaid-certified bed could have admitted the resident.

7. Resident financial information assists facilities to identify potential divestiture problems. We understand the indignation of our members at the growing numbers of "would be" poor persons who are divesting their assets to qualify for Medicaid. However, we also understand that most of these practices are legal if done correctly. The problem being expressed by many of our members is that residents who state that they are Medicaid-eligible at the time of admission have become so through divestiture that was done incorrectly. Their Medicaid applications are subsequently denied, and the facility is left with no recourse for payment. At minimum, the facility will absorb 60 days of care costs because of the notice requirements referenced in Item 3 above.

8. Facility access to resident financial information can help the resident protect his or her assets. Our facilities are aware through personal experience that some residents become poor because family members misuse resident funds. Proper disclosure of finances helps a facility keep track of such situations and can avoid extremely unpleasant litigation on behalf of residents.

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For all the reasons above, we believe that prohibiting facilities from requesting and reviewing resident financial data does not violate per se relevant statutory provisions. Furthermore, such information serves many legitimate needs of providers. The well-intentioned zeal on the part of those who watch-dog long-term care facilities does not take into account the basic fact that these providers must operate with prudent business practices if there is to be long-term care given at all. The lack of response on the part of federal and state governments to the increased costs of care have been disheartening at best. Further restricting facilities' means of stretching their resources by denying them access to resident financial information will only exacerbate an already-difficult fiscal climate.

We are requesting clarification from your agency about whether Mr. Kummer's letter expresses official HCFA policy on this issue. In that the letter has already found its way to a number of ombudsmen in states other than Michigan and is being used by some ombudsmen as an official federal pronouncement establishing, in effect, "first come, first serve" nursing home admission policies, we hope you are able to respond to our request as soon as possible.

Thank you for our assistance.

Sincerely

Sheldon Goldberg

Sheldon L. Goldberg
President

cc: Mr. Anthony Tirone, Esq., Director
Office of Survey and Certification
Health Standards and Quality Bureau

Enc.
smw/40

AMERICAN ASSOCIATION OF HOMES FOR THE AGING

OBRA AND OTHER REGULATIONS ISSUANCES YET TO BE RELEASED

			OBRA REGULATIONS	STATUTORY DEADLINES	ACTUAL/ESTIMATED PUBLICATION DATE
MCPA	BPD	396 F	Final, final version of Requirements for Participation (12/02/89 regulation)	No deadline in law	Final regulation Published Sept. 26, 1991; Effective April 1, 1992
	BPD	477 F	Costs charged to patient funds	July, 1988	Final regulation published 11/12/92; Effective 10/1/93
	BPD	488 F	Restraints, Drugs, Nurse Staff Waivers, State Statement of Medicaid rights, Swing Beds, Administrator Standards (Omnibus Regulation)	Nurse staffing waivers October 1988 Administrator standards October 1988	Proposed regulation Published February 5, 1992
	BPD	661 F	PASARR	October, 1988	Final Rule with Comment Period 11/30/92; Effective 1/29/93
	BPD	662 F	Nurse Aide Training and Competency Evaluation; Nurse Aide Registry	January, 1989	Final reg. published Sept. 26, 1991; Effective April 1, 1992
	HSQ	156 F	Survey, Certification, and Enforcement	January, 1990 October, 1988	Proposed regulation Published August 28, 1992
	HSQ	180 F	Minimum Data Set/Assessment Instrument	April, 1990	Proposed regulation Published December 28, 1992 Comments due February 26, 1993
	BPD	396 F	Medicare and Medicaid Requirements for LTC Facilities		Final Rule; Technical Corrections; Published 9/23/92
	HSQ	183 F	Medicaid Program; Elimination of Certain Written Documentation Pertaining to LTC Facilities		Final Rule; Effective 11/20/92

		OTHER REGULATIONS	STATUTORY DEADLINES	ACTUAL/ESTIMATED PUBLICATION DATES
MCPA		Clinical Laboratory Improvement Amendments (CLIA)	July, 1991	Final with comment period March 14, 1990;
	HSQ 176	Standards (complexity model)		Final with comment period February 28, 1992; Effective Sept. 1, 1992

Coordination of the MDS With PASARR and Other Assessment Systems

ISSUE: AAHA fully supports maximum coordination of the RAI/MDS with other assessment protocols, particularly the PASARR process. We fully concur with the Administration's determination (as stated in the Final Rule With Comment Period for Medicare and Medicaid Programs; Preadmission Screening and Annual Resident Review, Federal Register, November 30, 1992) that the annual RAI/MDS for nursing facility residents with MR or MI can serve as the Level 1 Screen for the Annual Resident Review. However, we feel strongly that this provision falls far short of what is needed to reduce or eliminate the existing duplication of efforts and unnecessary expenditures of already scarce resources.

AAHA is cognizant of HCFA's position that the requirement for Annual Resident Reviews to be performed by the State mental health (MH) and mental retardation (MR) authorities is statutory, and therefore cannot be eliminated absent a legislative remedy. We are not in total agreement with Administration's conclusion that there are no alternatives to the existing process, however, and we believe there are regulatory approaches under both the PASARR and RAI/MDS processes that would alleviate some of the current problems States are experiencing.

It is true that the statutory provisions related to PASARR currently require the identification of MI or MR and a determination by the State mental health and mental retardation authorities of whether specialized services and/or NF care is needed. It is also true, however, that the law does not specifically address the Level 1 and Level 2 PASARR screening process that has been developed by HCFA. AAHA believes that much of the information required on the Level 2 screen as necessary for the MH and MR authorities to make determinations, particularly for long-standing nursing facility residents with MI or MR, can be gleaned from the RAI/MDS. We therefore propose one possible alternative (which we believe can be implemented under current regulatory authority) to the current process of MH and MR authorities repeatedly duplicating much of this material for use in the ARR.

AAHA's proposal would be to allow the MH and MR authorities to determine for those residents with MI or MR whose mental status and/or level of intellectual functioning has remained stable over a two-year period, based on ARR criteria and on-site evaluation and record review, whether the data contained in the RAI/MDS is sufficient to make a determination of continued need for NF services and/or specialized services, or whether further evaluation is required.

We recognize that the delegation of authority to conduct these evaluations to NFs is prohibited by statute. However, we believe this proposal to have the State MH and MR authorities conduct ARRs for long-standing nursing facility residents with MI or MR based on the RAI/MDS is consistent with HCFA's position that the RAI data may be used by the State MH and MR authorities in conducting PASARR evaluations. Further, since the State MH and MR authorities would be applying the RAI data to the PASARR screen criteria and making the decision as to whether the data is sufficient to make a determination, with the option to conduct further evaluations if needed, we do not believe this approach constitutes a violation of the statutory mandate that there must be two processes for these two populations.

The OBRA mandate for oversight and/or intervention by the State MH and MR authorities would not be compromised by allowing these authorities the ability to make a determination based on RAI data for these long-standing MI and MR residents. As HCFA states in the Preamble to the November 30 Final Rule on PASARR (Federal Register, p. 56452), NF residents who have been determined to be MI or MR, but who are in need of nursing facility services have already been subject to a level 2 screen and are in the State tracking system for PASARR. It is assumed that the care needs associated with the MI or MR would be reflected in the RAI/MDS for these individuals. Any significant change in status would trigger a new RAI and ARR and would therefore be known by the State MH and MR authorities. A newly-discovered MI or MR would also precipitate this process and would therefore also provide notification to the proper authorities.

AAHA believes this proposal would (1) meet the OBRA mandate for maximum coordination of the resident assessment process with any State-required preadmission screening program; (2) result in greater cost efficiency by expanding the applicability of RAI/MDS data when appropriate, and thereby reducing duplicative testing and effort; (3) provide relief from the State MH and MR authorities being compelled to repeatedly conduct lengthy and intensive evaluations on residents whose mental and intellectual status has remained stable; and (4) reduce PASARR evaluations which may be overburdensome and unnecessary in terms of both professional and resident time.

In the event that HCFA does not agree that such a process can be implemented under current regulatory authority, we strongly recommend that the Administration propose a statutory amendment to this effect. AAHA would be happy to work with you on developing this amendment.

RECOMMENDATION: Amend 483.20(b)(5) to include "(i) State MH and MR authorities may determine for those residents whose mental status and/or intellectual functioning has remained stable over a 2-year period, based on Annual Resident Review criteria as defined under Subpart C, 483.100 et seq., and on-site evaluation and record review, whether the data contained in the annual RAI/MDS is sufficient to make a determination of continued need for NF services and/or specialized services, or whether further evaluation is required."

Mr. WAXMAN. Thank you very much, Mr. Goldberg.
Mr. Chies.

STATEMENT OF STEVEN CHIES

Mr. CHIES. Thank you, Mr. Chairman.

My name is Steve Chies. I am the administrator of Park River Estates Care Center, a 104-bed facility located in Coon Rapids, Minn. My family has been in the long-term care business for 28 years. I am here today representing the American Health Care Association, and we will focus our remarks on the topic at hand, which is Medicaid eligibility and the asset transfer provisions.

In a perfect world, no one would get sick or need long-term care. If they did require long-term care, that service would be readily available at a cost that would be affordable and without having to dip into one's personal assets as a consideration for that care. Unfortunately, we don't have a perfect world nor perfect system. The elderly believe they can rely on Medicaid, which we know is totally inadequate to pay for long-term care services, and usually rely on their own personal income or personal savings to provide long-term care services, and the ones who are able to, become eligible for medical assistance through one means or another.

Medical assistance, as other panelists have spoken and will speak to, is a payer which requires somebody to basically become impoverished before they can retain any assistance from either the State or the Federal Government. It was designed and should be designed to be the payer of last resort. It is rapidly becoming the tool to protect assets from the nursing home and to determine how a person should shelter their income going forward much to the detriment of both the State and the Federal budgets.

Most of the elderly don't want to go on welfare. They come from a period of time when going on welfare was like going to the poor farmer and going on the dole, and that was a fate worse than death. The pressure from their adult children and from family members to protect their inheritance and are encouraged to talk with attorneys and estate planners and to do so. Qualifying for medical assistance may provide an inheritance to adult children, but it limits the choice, the options, and the opportunities for the elderly to utilize health care services other than a nursing home.

In my facility, we have seen elderly individuals come into the facility with little or no assets and utilize nursing home services when, if they would have had some supportive services outside the nursing home, they could have conveniently gone to an apartment or to some other type of assisted living. While some of those services are provided in Minnesota by the Medical Assistance Program, the funding is limited, and if you don't have the money available those services are unavailable for most elderly individuals.

There has been some discussion about the scope of this problem. The American Health Care Association along with the National Governors Association and other associations encouraged the Senate Finance Committee to have a study conducted. The General Accounting Office will be producing that study very shortly, and we should have some definitive answers as to the scope and the nature and the severity of the problem.

We support certain provisions of the Catastrophic Act which was passed in 1988—specifically, the spousal impoverishment, which gives reasonable protection to the noninstitutionalized spouse and still allows an individual to become eligible for medical assistance.

We do have five recommendations which I will briefly summarize. One is, we think the look-back period for eligibility should be extended from 30 months to perhaps 60 months. We would like to see the multiple transfers clarified; we would like to see a prohibition on the use of nonexempt assets which could be used to purchase exempt assets; and we would like to see a greater use of liens to recover assets; and, finally, we would like to see the States promote recovery programs.

While I am sure that the recommendations that we have and that other people will have when the final bill passed will assist both Congress and the States in saving some money from the budget, I am certain also that the elder law attorneys and the estate planners will find other means of dealing with those issues as they come up. Basically, this is one symptom of what is going on in the marketplace out there.

The American Health Care Association has a proposal which would include wrapping long-term care services into a comprehensive health care reform package which would include both a public and private partnership in providing services going forward, including long-term care insurance.

That is a summary of my testimony, Mr. Chairman, and I thank you for this opportunity.

[Testimony resumes on p. 405.]

[The prepared statement of Mr. Chies follows:]

STATEMENT OF STEVEN CHIES,
ADMINISTRATOR, PARK RIVER ESTATES,
ON BEHALF OF AMERICAN HEALTH CARE ASSOCIATION

Mr. Chairman, members of the committee, my name is Steve Chies. I am the Administrator of Park River Estates, a 104 bed long term care facility in Coon Rapids, Minnesota. I am pleased to appear before the committee today on behalf of the American Health Care Association (AHCA), a nonprofit trade association representing more than 11,000 long term and residential care providers through its fifty-one affiliates. My remarks today will focus on one very important aspect of President Clinton's FY94 budget proposals; namely, the savings associated with prohibiting the artificial qualification for Medicaid benefits through a process commonly known as, "asset transfer." The President has proposed the enactment of reform efforts to close loopholes in existing laws, thus prohibiting the inappropriate qualification of the nonpoor for Medicaid benefits. The goal of this proposal is to ensure that individuals with personal assets pay their fair share before qualifying for nursing facility benefits under Medicaid. AHCA applauds President Clinton's efforts in this regard and is committed to assisting this committee in helping him realize this important policy objective.

Eligibility for Nursing Facility Benefits under Medicaid

Eligibility for Medicaid long term care benefits is determined by the individual states. Basically, eligibility results from low income and few assets. In most states, individuals will not qualify for Medicaid long term care benefits until they have less than $2,000 in "countable assets" (some assets, such as a home, clothing and automobile are not "counted" towards eligibility). In addition, there are income limitations for Medicaid beneficiaries. States utilize two methods of establishing income criteria. In 31 states, an individual is eligible if their income is not sufficient to pay the private cost of nursing facility care. In the remaining 19 states, an income cap, no higher than 300 percent of the federal Supplemental Security Income benefit level has been established by federal law. In 1991, this level was determined to be $1,221 per month. Federal law also provides for financial protection of the community spouse of an institutionalized individual.

The process of qualifying for Medicaid benefits with regards to disposing of personal assets is commonly referred to as, "spending down." This is simply a matter of disposing of one's "countable" assets prior to applying for Medicaid benefits. Federal statutes governing the disposition of assets in order to qualify for nursing facility benefits under the Medicaid program can be found at Sec. 1917(c)(1) of the Social Security Act. This section provides that in order to meet its requirements, no individual may qualify for such benefits if they have disposed of resources for less than fair market value for the thirty month period preceding either their institutionalization or their application for Medicaid benefits. This same body of federal law permits the states to include in their plans, the imposition of a lien on the homes of deceased, Medicaid beneficiaries (within limitations regarding the home's use as a residence for certain family members of the deceased) so that the state may make a claim on the value of the home equal to the state monies spent on the care provided to the deceased through the Medicaid program. However, shortcomings in this law, as well as other factors have discouraged states from adopting such programs.

The Medicaid Catastrophic Coverage Act of 1988 instituted a number of changes in the law dealing with the ability of individuals in need of long term nursing facility care to shelter or divest assets. The primary effect of these changes has meant that neither an individual nor their spouse is required to "spend-down" all of their resources before the individual can become eligible for Medicaid coverage for nursing facility care. The provisions of this law are commonly referred to as, "spousal impoverishment protections." They guarantee that the community-based spouse of an institutionalized individual need not impoverish themselves in order to obtain Medicaid benefits for their institutionalized spouse. Each state decides how much income may be retained by the community spouse. However, federal statute sets minimum as well as maximum dollar amounts on how much income the community-based spouse may receive.

It is important for this committee to understand that AHCA does not oppose the financial ability of the community-based spouse to remain in their home. However, with no limitations on the value of the home that is exempt from determining Medicaid eligibility, there arises an opportunity to shelter income that could otherwise be used for health care services. AHCA considers the primary tenants of the spousal impoverishment provisions of the law to be in the best interest of the public as well as both the federal and state governments. We urge you to retain those provisions of current law which ensure adequate incomes for community-based spouses yet do not promote nor allow for the inappropriate sheltering of assets available to support the care of the institutionalized spouse. Conversely, we urge you to review these statutes for potential abuses and to enact appropriate safeguards that are in the best interest of public policy.

Asset Transfers

Since the enactment of the Medicaid Catastrophic Coverage Act of 1988, nursing facilities and various agencies within state governments have reported an increase in the Medicaid-sponsored utilization of nursing facility services. The inference drawn from these observations has been that a certain portion of this population has inappropriately qualified for Medicaid benefits through asset transfers. While these observations are somewhat subjective, the phenomenon nonetheless exists. Some of the first studies on methods to counter the practice of asset transfers was conducted in 1988 by the Office of the Inspector General entitled, "Medicaid Estate Recoveries" and the General Accounting Office's (GAO), "Medicaid: Recoveries from Nursing Home Residents' Estates Could Offset Program Costs." Both reports supported the contention that the individual states were not sufficiently exercising their rights to recover state monies spent on behalf of nursing facility residents by placing a lien on their property. The OIG report estimated that if the states undertook aggressive estate-recovery efforts, $589 million could be recovered. However, at the time, states only generated $42 million annually through these federally approved programs. A more recent study by Lewin-ICF (January 1992) entitled, "Curbing Medicaid Estate Planning: Potential Savings to the Medicaid Program" concludes that, "...we estimate that the Medicaid program could potentially save nearly $2.5 billion over current practices if asset transfer was curbed." In February 1992, the Congressional Budget Office (CBO) reported to the Senate and House Budget Committees that the imposition of the recommendations made by the aforementioned OIG study would save $75 million in 1993 and $1.3 billion over the 1993-1997 period, and "substantially more in the future."

In order to further quantify the practice of asset transfers and to reconcile the disparity of the various dollar estimates associated with the studies noted above, AHCA, in conjunction with the National Governor's Association and others worked with members of the Senate Committee on Finance and the Senate Special Committee on Aging in October 1992 to request from the General Accounting Office, a quantitative analysis of asset transfer practices. The purpose of this study is to identify and quantify those practices which lead to the inappropriate qualification of Medicaid services. In their request for this analysis, Senators Bentsen, Packwood, Pryor, Cohen and others asked for GAO to address the following questions:

- How wide spread is the practice of transferring assets?
- What is the impact of these transfers on Medicaid?
- To what extent do asset transfers affect the demand for private long term care insurance?
- To what extent are states enforcing the current statutory and regulatory requirements governing asset transfers?

According to individuals involved in the generation of this study, GAO will present initial findings in April 1993. Should the GAO provide the Senate, as well as this committee with quantifiable data demonstrating that there is a significant misuse of existing law and its intent, we would hope that this committee, the Administration, and others would develop solutions to the inappropriate utilization of scarce Medicaid resources.

Elder Law and Estate Planning

A fairly recent development in the area of long term care has been the emergence of what is referred to as "Elder Law." As the name implies, Elder Law attorneys specialize in the legal affairs of the elderly with emphasis on fiscal concerns and eventualities associated with aging. One goal of Elder Law is to allow couples to retain more of their savings and monthly income while ensuring that they receive the benefit of Medicaid assistance to pay for needed nursing home care. Organizations, attorneys, and estate planners have become extensively involved in this area. Articles in the popular press offering information on how to "protect" assets from the scrutiny of Medicaid are commonplace. Ironically, even the federal inadvertently government is promoting the practice of Elder Law through the Graduate School of its U.S. Department of Agriculture Correspondence Program which offers several courses for students on: Nursing Home Law; Wills, Trusts and Estate Administration; and Financing Long Term Health Care. Although legal, the practice of certain aspects of Elder Law seemingly conflicts with public policy objectives of the Administration.

There are numerous ways to "spend down" or deplete your personal assets without loosing control of them. Elder Law attorney's are especially skilled at identifying legal ways to create Medicaid eligibility for their clients while giving them, or their families, control of the individual's assets. Asset ownership manipulation, the use of trusts, and asset diversion are just a few examples of legal ways in which individuals can shelter their personal holdings from the determination of Medicaid eligibility.

Clearly, this phenomenon is growing. Policy makers should be urged to restrict these practices to the extent possible. The Medicaid program is severely strained financially. The use of scarce Medicaid resources for those that could otherwise afford them clearly conflicts with sound public policy.

Recommendations of the American Health Care Association

The American Health Care Association believes that Title XIX of the Social Security Act can be amended in several areas to reasonably restrict the transfer of assets, to close Medicaid long term care eligibility loopholes, and to require more aggressive estate recovery programs in states. Accordingly, we offer the following recommendations for your consideration:

1. **Extend the "look-back period" from 30 months to 60 months on transfers for less than fair market value (FMV) made for the purpose of qualifying for Medicaid.**

Under current federal law, any transfer for less than FMV made within 30 months of applying for Medicaid and made for the purpose of divesting assets to become eligible for Medicaid will disqualify a person from Medicaid eligibility until the uncompensated value of the assets can be recouped. 42 U.S.C. Section 1396p(c).

We respectfully request that the "look-back period" be extended from 30 to 60 months. We believe that the 30 month period is too short and still allows people to divest their assets to accelerate eligibility for Medicaid.

2. **Clarify that multiple transfers for less than FMV made during the look-back period will be viewed cumulatively, rather than separately.**

As indicated, Medicaid law contains a "look-back period" that prohibits a transfer of assets for less than FMV within 30 months of a determination of eligibility, if the purpose of the transfer is to qualify for Medicaid. The law provides that the penalty period during which a person will be ineligible for Medicaid will be the lesser of:

a. 30 months; or

b. the number of months resulting from dividing the uncompensatede value of the transferred resource by the Statewide monthly average room rate for a Medicaid certified facility. 42 U.S.C. Section 1396p(c).

To illustrate (b) above, let us assume that Mr. Jones gives his daughter a gift of $24,000 within the 30 month look-back period. Let us also assume that the average monthly Medicaid facility reimbursement rate is $3,000. Applying the above formula, Mr. Jones would be ineligible for Medicaid for eight months (the lesser of 30 months or $24,000 divided by $3,000.)

Our concern rests with the state Medicaid agencies' treatment of multiple transfers for less than FMV within the 30 month look-back period. Expanding upon the above hypothetical, let us assume that Mr. Jones made three transfers to his daughter each for $24,000, each for the purpose of qualifying for Medicaid and each for less than FMV during the 30 month look-back period. The issue presented is whether Medicaid ineligibility would continue to be eight months or would grow to 24 months ($72,000 divided by $3,000). We firmly believe that these transfers should be viewed cumulatively, rather than separately, and ineligibility should grow to 24 months. Federal law is not clear on this issue, and many state Medicaid agencies continue to view the above transfers separately. Accordingly, we respectfully recommend that the federal Social Security Act be amended to clarify this issue.

3. During the look-back period, prohibit the use of non-exempt assets for the purchase of (or extraordinary payment on) assets that would be exempt from consideration in

determining Medicaid eligibility.

This amendment is designed to stop a practice where a Medicaid applicant, just prior to filing the application, uses all of his/her remaining liquid non-exempt assets (e.g. cash, certificates of deposits, etc.), to buy an exempt asset such as a bigger home or artwork to place in their home, or to pay off an exempt asset such as a mortgage. The problem here is that the Medicaid applicant is using assets that should have gone to pay for his/her long term care for another purpose, so that the taxpayers will have to pay.

We recommend that the federal Social Security Act be amended to prohibit this practice, if the reason for such transfers is to qualify for Medicaid. Furthermore, all transfers of non-exempt assets (e.g. CDs) to exempt assets (e.g. artwork for the home) made during the look-back period should be presumed to be for the purpose of qualifying for Medicaid, unless the Medicaid applicant or his/her legal representative can prove otherwise.

4. **Require, as a condition of Medicaid eligibility, that an applicant agree to immediately have a lien placed on all of his/her real and personal property.**

Under current federal law, a lien cannot be placed on a recipient's personal property to recover Medicaid benefits correctly paid until after the recipient's death. 42 U.S.C. Section 1396p(a). A lien also may not be placed on a Medicaid recipient's real property prior to his/her death for benefits correctly paid if there exists a spouse, dependent child, or sibling having an equity interest in the property, residing on the property. Id. By requiring a Medicaid applicant to agree to have a lien placed on his/her real and personal property as a condition of Medicaid eligibility, this amendment would ensure that the state Medicaid agency will have priority to recover tax dollars used to pay for the Medicaid recipient's long term care.

It is important that this amendment also include a provision that the state Medicaid agency should not be allowed to execute its lien on a Medicaid recipient's real property until all dependents (as the term is currently defined in 42 U.S.C. Section 1396p(a)) have ceased to reside on the property. Such an amendment can be made at 42 U.S.C. Section 1396p(a) or (b) of the federal Social Security Act.

5. Require states to institute aggressive estate recovery programs.

Current law allows (but does not require) states to place liens on the property of living Medicaid recipients, and to recover from the estates of deceased recipients, with certain limitations. Studies by Office of the Inspector General and the

General Accounting Office in 1988 and 1989 found that very few states had aggressive estate recovery programs in place, and even fewer utilized liens on property of living recipients. The reports found weak enforcement of asset transfer provisions as well. The Office of the Inspector General estimated that in 1988, an estimated $589 million could be recovered annually if all states mounted an estate recovery program comparable to that in operation in Oregon. This annual savings in 1988 dollars does not include any savings that would result from changes in transfer of asset provisions.

In the absence of a statutory change making such programs mandatory, state Medicaid programs could be encouraged to implement more effective programs by allowing states to retain a greater share of recovered assets. States would also benefit significantly from aggressive technical assistance from HCFA. These low cost administrative activities could yield significant budgetary savings through better estate recovery efforts.

Conclusions

If this Administration is to enact comprehensive, national health care reform, then long term care must be part of that effort. While we applaud the Administration's efforts to ensure that Medicaid resources are made available to only those that truly need them, we all must recognize that restrictions on asset transfers will make only a small, yet important contribution.

All of us are aware of the daunting costs associated with addressing both acute as well as long term health care services. Much more must be done to ensure that all Americans have equal access to the entire spectrum of health care services.

The American Health Care Association has developed a proposal to achieve this policy objective, while simultaneously constraining federal and state expenditures on long term care services. Our Association believes that a fiscally sound public health care system for the truly needy should be buttressed by a partnership with the private sector -- namely, private long term care insurance.

In order to meet the nation's growing long term care needs without both emptying the public purse and driving down the quality of care, our society cannot afford to rely soley upon government. Instead, we should encourage and enforce an expectation of personal responsibility on the part of those with access to the means to plan for and pay for long term care. Government must help in this effort through measures to ensure that individuals have the information and resources they need to take on personal responsibility for meeting their long term care needs. AHCA believes that there are several steps Congress can take immediately to further this policy objective. AHCA's plan calls for: public education on long term care costs, the limits of government programs, and planning for long term care needs; develop and impose federal standards and consumer protections for long term care insurance; and tax incentives for the purchase of long term care insurance.

While we are aware that private long term care insurance is a relatively new product, we believe that with strong federal and state oversight of its development and implementation, our society can shift its reliance upon government expenditures for long term care services to the private sector, benefiting both the individual consumer as well as state and federal governments.

Mr. Chairman, this concludes my remarks. At this point, I would be pleased to answer any questions you or other members of the committee may have. Thank you.

Mr. WAXMAN. Thank you very much, Mr. Chies.
Ms. Nemore.

STATEMENT OF PATRICIA NEMORE

Ms. NEMORE. Thank you very much, Mr. Chairman.

I am Patricia Nemore, a staff attorney with the National Senior Citizens Law Center here in Washington. We are a legal services and Administration on Aging-funded support center for legal services and other advocates representing low-income older people around the country.

In the last 5 years, particularly since the passage of the Catastrophic Coverage Act, there have been enormous amounts of energy focused on this issue of transfer of assets, and to our way of thinking enormous energy which might have been put to better use in directing toward developing a long-term care program that gets us out of the situation that Mr. Russo so eloquently described.

At the same time that this committee seeks now to focus on changes that will increase the burden on individual—and I do repeat, it is individual—elderly and disabled people who have the misfortune of needing long-term care as opposed to some other kind of care in the system, we are bombarded with news reports of doctors' salaries that are five times greater than that of the average male in the country, we have the Kaiser Commission telling us that inflation contributes to 31 percent of Medicaid increases, we read reports of increased profits in both the nursing home and hospital industry, we read that drug prices are inflated at five times the rate of general inflation in the country. Medicaid programs are paying for high salaries for luxury cars, for business meetings in resort settings, and for association fees and attorney fees, and yet the Federal Government will not direct the State Medicaid programs about what kinds of reimbursement is appropriate in their Medicaid program; and, as you have pointed out, Mr. Chairman, we are now seeing reduced activity in the Federal Office of Inspector General as well as proposed cuts in State fraud control units.

The fact is that most families who are faced with the need for long-term care cannot in any reasonable way plan for the catastrophic cost of long-term care. Shopping for nursing facility services, anyone who has done that knows that the quoted private pay rate covers only the barest essentials of room and board. A private pay rate of $130 per day does not include charges for incontinent care, for incontinent supplies, for hospital gowns, for hair care, laundry, personal hygiene items.

People paying privately have no control over changes in the private pay charges. They have little recourse if they consider the charges excessive other than being told to find another nursing facility, and we know how difficult that is and that the results in another facility wouldn't necessarily be any different.

Nursing facilities manipulate their participation in Federal programs so that the Federal nursing home reform law protections may not even apply to people who are paying at private pay rates. Nursing homes discriminate against Medicaid recipients in the nursing homes. So people who have lived by the rules all their lives, who have taken care of themselves and planned for their needs, are at the mercy of a system that seems virtually unsusceptible to planning. In an effort to retain some element of control, they turn to Medicaid, but they are demeaned by being made to feel that they are trying to beat the system or get something for nothing.

Nursing home residents and their families concerned about retaining enough money to meet, for example, the need of a spouse for home care have to hire the equivalent of a tax lawyer to advise them on the complexities of the Medicaid law.

I hope that in considering this issue Members of Congress will not forget what led to the passage of the Medicaid Protections and the Medicaid Catastrophic Coverage Act in 1988. There were stories of spouses who had been married for decades who needed to divorce because the spouse at home was not able to live on what Medicaid allowed for the spouse at home when the other spouse needed to enter an institution.

The Congress should be proud of the change in the law that was passed that year, and we certainly in our program hear of clients who had been forced in past years to live on the most incredibly small amount of money being pleased at now getting a larger income contribution from their spouse.

We certainly do not disagree that some of the practices that are allowed under current law are more likely to lead to abuses than others. One of the proposals that we have heard today several times is to increase the look-back period. I would strongly oppose that. It is administratively infeasible and puts a tremendous burden on the people applying for the program.

As I have stated in our testimony, we are very interested in working with the subcommittee. We are happy to look at proposals that are being considered. We have not seen specific proposals other than in the testimony today. We are concerned always about the effect of our efforts to fix abuses tend to have on the people who really need to be protected in the system, and so we are very anxious to look at specific proposals and see that we can ensure that there are safeguards in those proposals.

Thank you, Mr. Waxman.

[Testimony resumes on p. 423.]

[The prepared statement of Ms. Nemore follows:]

TATEMENT OF PATRICIA NEMORE, STAFF ATTORNEY, NATIONAL SENIOR CITIZENS LAW CENTER

Good morning. Thank you, members of the Subcommittee for inviting me to testify this morning on reconciliation consideration of tightening of transfer of assets prohibitions and estates recovery procedures in the Medicaid program. I am Patricia Nemore, a staff attorney at the National Senior Citizens Law Center. The Law Center is funded primarily by the Legal Services Corporation and the Administration on Aging to provide legal and technical assistance to attorneys and other advocates representing older, low-income people throughout the country.

While I am grateful for this opportunity to participate in the Subcommittee's discussions about possible changes in the transfer of assets and estate recovery portions of the Medicaid law, I cannot begin that portion of my remarks without first pointing out the cynical nature of the exercise being undertaken by this Subcommittee. While all evidence points in different directions for seeking cost-savings in health care programs, program beneficiaries -- in this case, those older or disabled people unlucky enough to need chronic long-term care -- are asked to carry the burden of cuts. An earlier panel today has addressed cuts in the federal administrative payment to states. Those cuts, especially reduced payments for survey and certification activities and for state Medicaid fraud control units, go to the heart of quality control and control of fraud and abuse, and thus they, too, though more indirectly, place the burden on program beneficiaries.

In the last six months, the newspapers have been full of stories about the substantial incomes of health care providers, about high profits in the healthcare industry, about runaway inflation in health care and about cuts in the budgets of agencies charged with doing something about fraud and abuse.

- - An employee benefits firm finds that the average salaried physician received pay and bonuses totaling $139,732 in 1992. According to the American Medical Association, the average self-employed non-federal physician earned $185,600 in 1990. The average full-time male worker in the United States earned $29,421 in 1991, or 21% of the salaried physician's pay.[1]

- - The Kaiser Commission on the Future of Medicaid reports that Medicaid price inflation accounted for 31 percent of Medicaid expenditure growth in the period from 1988 to 1991. Increased expenditures per beneficiary, including increases in payments to providers resulting from Boren Amendment litigation, accounted for 28 percent of the increases during the same period of time.[2]

- - A nursing home industry spokesperson comments, in a report about increased profit margins for the industry in 1990, that "the trend for profit margins will continue to be positive."[3]

- - The American Hospital Association releases figures showing a 23% increase in hospital profits in 1991.[4]

-- A report by the Senate Special Committee on Aging released earlier this year indicates that drug prices increased at four times the rate of inflation for 1992.[5]

-- The Office of Inspector General at the Department of Health and Human Services, whose job it is to prosecute fraud and abuse in the Medicare and Medicaid programs, is closing 10 of its 57 offices and abandoning 1,500 pending cases for lack of staff. It will virtually cease to operate in 14 states. Its recoveries decreased 20% from 1991 to 1992.[6]

Other stories from newspapers around the country chronicle increased Medicaid reimbursement rates, Medicaid payments for high salaries, for luxury cars, for business meetings in resort settings, for attorneys fees and association dues (read lobbying costs).[7] Yet we are here today to talk about putting greater burdens on individual low and middle-income users of our health-care system, because we can get "scorable" savings from these approaches. Because the Congress and the administration have not yet shown a willingness to be more directive at the federal level about how Medicaid reimburses providers or to increase, rather than decrease, the federal commitment to fighting fraud and abuse.

Protections Against Spousal Impoverishment

Now, onto the matter about which you invited me to testify. The Law Center represents low income people. We, too, are outraged by the occasional call we receive or story we see suggesting that greedy lawyers or greedy adult children are seeking to abuse the Medicaid system by sophisticated manipulation of the law's provisions.

But the fact is that most families cannot, in any other reasonable way, plan for the catastrophic medical expense of long-term care. Anyone shopping for nursing facility services knows that the quoted private pay rate covers only the barest essentials of room and board. A private pay room rate of $130 per day does not include charges for incontinent care, for incontinent supplies, for hospital gowns, for hair care, laundry, or personal hygiene items.[8] People paying privately have no control over changes in these charges; they have little recourse if they consider the charges excessive. Nursing facilities manipulate their participation in federal programs so that federal nursing home law protections may not even be available to people paying privately. People who have lived by the rules all their lives, who have taken care of themselves and planned for their needs, are at the mercy of a system that seems virtually unsusceptible to planning. In an effort to retain some element of control, they may turn to Medicaid, but are demeaned by being made to feel as if they are trying to beat the government or get something for nothing. Nursing home residents and their families, concerned about retaining enough money to meet, for example, a spouse's need for home care, have to hire the equivalent of a tax lawyer to advise them on the complexities of Medicaid law.

Let us consider what, exactly, has happened to Medicaid long-term care law in the last five years. I was privileged, in representing clients, to work with the staff of this Subcommittee and of the Senate Finance Committee in 1987 and 1988 when Congress was drafting the protections against spousal impoverishment that currently exist in the Medicaid law. It was at that same time that Congress substantially altered existing prohibitions against transfer of assets.

The passage of both of those provisions in 1988 represented the first time that Congress had addressed the devastating impact on a family of the need for chronic long-term care by one member of that family. Prior to the 1988 legislation, the at-home spouse of a nursing home resident was permitted to receive a contribution of about the amount of the SSI single person benefit rate (currently $434 per month, roughly 75% of the poverty guidelines for one person) from her spouse, not more. All the couple's assets had to be used to pay for care for at least one month, sometimes for six months, or until the combined assets were reduced to the low level permitted to be retained by a Medicaid recipient (about $2,000). At the end of that time, only the assets in the name of the spouse at home were left for her. If the family assets happened to be in the name of the nursing home resident, they had to go to pay for his or her care. If, on the other hand, they were all in the name of the at-home spouse, s/he could keep them all, with no further contribution required. Family financial well-being in the long-term care arena was a gamble. Winning or losing depended on who held the assets and who got sick. Newspapers were filled with heart-wrenching horror stories of couples married for decades who were forced to seek divorces so that the at-home spouse could maintain some financial security in the face of the long-term care needs of the other.

The 1988 legislation, included in the Medicare Catastrophic Coverage Act and not included in the repeal of other portions of that law in 1989, changed the income and resource provisions of Medicaid for married people needing care in an institution. Now, the at-home spouse is entitled to a minimum that is more than two and one half times the pre-1988 allowance (currently $1149 per month). The spouse is allowed an additional amount if s/he has exceptionally high shelter costs, or can show unusual circumstances requiring a larger contribution. The spousal allowance is not a lot of money by any standard, but is an enormous improvement over prior law.

The original draft of spousal protections did not contain any resource provisions, as the most significant problem was considered to be the lack of sufficient income for the at-home spouse. Some members of Congress thought that fairness demanded that at least one-half of a couple's assets (regardless of which spouse owned them) should not be protected from the costs of long-term care; others thought it important to have a minimum amount of assets protected before the "one-half" was measured. The compromise was a minimum resource protection of $12,000 (in 1993, the amount is $14,148) or one-half of all the couple's countable assets, but not more than $60,000 ($70,740 in 1993). The law provides mechanisms for the maximum to be exceeded, upon a showing of certain circumstances.

While some may think that by passing these provisions of the law, Congress turned Medicaid long-term care into a program for middle-class people, in fact, these provisions merely offered a possibility of greater equity where resources were unevenly distributed between the spouses. Medicaid had long served those middle class families who had the luck or vision to have the title to family assets in the name of the healthy spouse. Under the 1988 provisions, even if all the couple's resources are listed in the name of the applicant or resident only, the at-home spouse is still entitled to keep a portion of those resources.

Transfer of Assets

At the same time that spousal protections were included in the law, the federal prohibitions against transfers of assets were changed in numerous ways. The law was narrowed to apply only to transfers by people seeking Medicaid for nursing facility services, or for services under a home and community-based services waiver, whereas previously it had applied to all Medicaid applicants. (Prohibitions against transfers by SSI recipients were repealed in 1988, as well.) The penalty was directly linked to the cost of nursing home care. The look-back period was increased from 24 to 30 months. And the law was made uniform and mandatory on all states. A 1989 amendment mandated that transfers by the applicant or recipient's spouse must also result in a penalty to the applicant or recipient. Currently, the transfer provisions are as follows:

-- The state must penalize an applicant for nursing facility services if the applicant or his/her spouse has transferred assets for less than fair market value within 30 months preceding, or at any time after, application for Medicaid payments for nursing facility services.

-- The penalty is determined by a formula which requires dividing the uncompensated value of the asset by the average private pay monthly cost of nursing facility care in the State (or in a local area, at the State's option) to arrive at a number of months for which the State will not pay for care. The maximum penalty is 30 months.

-- There are exemptions from the penalty:

--transfers of the home to the spouse, to a dependent or disabled child, to certain siblings or to certain caretaker adult children;

--transfers of any resources to or from the spouse or an adult disabled child;

--transfers that were made "exclusively for a purpose other than to qualify for medical assistance;" or

--situations where the State determines that denial of eligibility would work an undue hardship.

It is these provisions, coupled with the resource protections against spousal impoverishment, that provide the framework for what is familiarly called Medicaid planning.

Responses to Subcommittee Questions

The Subcommittee has asked panel members to respond to several questions concerning transfer of assets and estate recovery.

1. What techniques do individuals with substantial assets now use in order to qualify for Medicaid nursing home services?

I am sure members of the Subcommittee are familiar with the exhaustive exposition of these techniques in Brian Burwell's "Middle-Class Welfare: Medicaid Estate Planning For Long-Term Care Coverage," prepared for the Health Insurance Association of America, September 1991. I believe Mr. Burwell's compilation of planning techniques is more complete than any prepared prior to that time by elder law members of the private bar.

In brief, Mr. Burwell describes such practices as

-- investing in exempt assets

-- putting assets in trusts or irrevocable annuities

-- paying off debts

-- transferring some assets but retaining enough to pay privately during the full 30-month penalty period

-- having third party joint tenants withdraw funds from joint accounts

-- paying family members for services provided

-- transferring the home to the community spouse or to adult children to avoid liens or estate recoveries.

2. How prevalent is divestiture behavior?

As Mr. Burwell has pointed out, the most direct evidence of "divestiture activity," however that might be defined, is in the astronomical growth of the elder law specialty. At a Health Policy Forum just one year ago, a charter member of The National Academy of Elder Law Attorneys (NAELA) reported that organization's membership had increased from 26 members in 1988 to 1600 members;[9] a NAELA directory published in December 1992 reports over 1,700 members. But the fact that hundreds of lawyers have some familiarity with various "planning" techniques does not, in fact, provide any evidence at all of how widely these techniques are adopted or what effect their use has on any State's Medicaid system.

As Mr. Burwell's article points out, many of the planning techniques, while theoretically possible and providing worthy intellectual exercise for the conscientious attorney wanting to leave no option unexplored, have adverse consequences that make their use undesirable. For example, the transfer of a house to adult children during the owner's life leaves the adult children with the original basis, rather than the stepped-up basis they would get it they inherited the house at the owner's death. Thus, while the transfer may protect the house from liens or estate recoveries, the countervailing tax consequences may offset the value of that option.

On another point, Mr. Burwell identifies paying off debts as one mechanism to "impoverish" an individual to make him/her eligible for Medicaid. If the person has no money after paying off the debts, s/he is, in fact, impoverished. Will Congress legislate against people paying their debts? I do not think so.

Other considerations exist. For some clients (although probably not a large number), the purchase of long-term care insurance might be preferred to the divestiture of assets. More relevant to all clients, however, is consideration of the consequences of being a Medicaid recipient seeking nursing facility services. To be in this situation is to subject oneself to the vagaries of a system that permits providers to choose their level of participation in the program (and therefore to tell prospective residents that no Medicaid beds are available), that results in residents being moved from bed to bed depending on whether Medicare or Medicaid is charged for a particular period of time, and that may result in fewer services being available to the individual resident. Any responsible, ethical attorney offering her client information and options about long-term care must include this information as well. Thus, to divest oneself of assets is to relinquish control and to limit choices.

3. Are there reasons for divestiture other than transmission of wealth to siblings or offspring?

Yes. While the 1988 law improved the financial circumstances for at-home spouses substantially over prior law, the current design of Medicaid, with its continued emphasis on institutional care, leaves any spouse who might her or himself need assistance while living in the community completely vulnerable. (The Administration's desire to eliminate the Medicaid personal care mandate as a cost-saving measure is an unbelievable step backward in what has been an inching forward during the last ten or so years toward providing services in the community.) Little public money or insurance is available for home and community-based care, so private funds would be necessary to meet the needs of the community spouse.

Other reasons exist for seeking to protect greater amounts of assets than provided by the law's formula. Family income may be generated largely by the couple's assets, whether in a family business or in other investments. To deplete the assets, then, also depletes income. Alternatively, the institutionalized spouse may have income that will cease to be paid, or be reduced, when he dies. (In the case of a social security benefit, for example, a couple's payment based on one spouse's record is equal to one and one half times the individual's benefit. When that individual dies, the benefit is reduced by one-third. Private pension income may cease altogether.) The spouse may wish to preserve income-generating assets to assure that she has enough income if her spouse predeceases her. The statute recognizes these possibilities and identifies a process to address this potential problem.

4. Should "loophole" closures (which have not yet been specified) extend beyond nursing home care to "other medical services?"

The protections against spousal impoverishment and penalties for transfers of assets contained in the Medicaid law were designed with considerable thought as to the potential needs of Medicaid nursing home recipients and their families. What may be viewed as loopholes under one set of facts are provisions that allow for various legitimate exigencies when viewed in a different light. In any case, the particular statutory scheme that gives rise to this discussion at all applies to the receipt of nursing facility services or services under a home and community-based care waiver. It has no application to other Medicaid services and should not be extended.

5. What statutory changes would you recommend to "close the loopholes" in current Medicaid law?

Sequential Gifts

Last year, some Members of Congress proposed to amend the law to prohibit or penalize the practice of making serial gifts in successive months to avoid the full transfer of assets penalty. The amendment did not pass. Serial gifts work as follows: An individual makes a gift of $20,000 in month one. Since the transfer penalty is based on the monthly cost of care, and assuming that cost to be $2500, the maximum penalty for the $20,000 gift is 8 months ($20,000 divided by $2500.) This penalty begins in the month in which the transfer is made. The next month, the individual makes a gift of $20,000 minus $2500, or $17,500. The penalty for that gift is 7 months, beginning in the month of the gift. But the individual is already under a 7 month penalty from the first gift. The penalty for the second gift runs concurrently with the first penalty, so no greater penalty is incurred than already existed. Each month, a gift of the previous amount less $2500 is made, so that each penalty is one month less than the previous one and they all run concurrently. At the end of the 8 months, the individual could have given away $75,000. If s/he had done so all in one gift, the penalty period would have been 30 months.

Sequential gifts can be addressed by a specific amendment to the statute that creates an exception to the rule that the penalty period runs from the date of the transfer. When the state determines that sequential gifts have been made, it may combine the value of all the gifts and determine the penalty based on that value. The Law Center is willing to work with members of the Subcommittee to draft specific language.

Liens and Estate Recoveries

Advocates for low-income older people have generally been concerned about the negative impact on clients of liens imposed on real property and of estate recovery programs, largely because of the possible inhibiting effect of these practices on people seeking Medicaid payment for services they need. Should the law be amended, however, to require states to impose liens and to engage in estate recoveries, we strongly recommend that clear understandable information delineating all qualifying exceptions to recovery must be made available to the recipient or his/her family or heirs before any claim can be enforced. Program beneficiaries or their families should be entitled to hearings to contest erroneous charges, to establish their entitlement to any exceptions, or to prove undue hardship. Current exceptions in the lien law for property resided in by adult disabled children need to be liberalized to be available to children who do not meet the SSI standard of disability.

6. If we close these "loopholes," how will applicants, their adult children, and estate planning professionals respond?

As Brian Burwell tells us, planning is rational economic behavior. Although it may result in the transfer of wealth to non-disabled adult children of individuals needing long-term care, in most cases it is the rational effort by people used to planning for their needs and taking care of themselves to address the terrifying problem of paying for astronomically expensive services that may be required for many years. Until the federal government addresses the long-term care needs of the population with national health policy, all efforts to tinker with the system are likely to be met with corresponding efforts to continue to protect the family from financial devastation.

Conclusion

It is difficult to respond to the Subcommittee's questions with specific comments since specific proposals are not on the table. We do not deny that the law is abused by some. It is not always easy to address the abuses without penalizing the people most in need of protection. But we are willing and able to work with the Subcommittee as it develops legislative proposals in this area.

1. Spencer Rich, "Average Staff Doctor Said to Earn $139,700," Washington Post, Wednesday, February 24, 1993, A3

2. "The Medicaid Cost Explosion: Causes and Consequences," Report of the Kaiser Commission on the Future of Medicaid, Review Draft,December 15, 1992, Executive Summary at iv.

3. "Nursing home profits continue to rise," Modern Healthcare, 11/23/92, at 14

4. "Hospital profits rose 23% in '91 - AHA", Modern Healthcare, 11/23/92, at 2.

5. Jack Anderson and Michael Binstein, "Fighting the Pharmaceutical Lobby," Washington Post, Sunday, February 14, 1993, C7

6. "Health Care Watchdog Unit Cuts Back," Washington Post, Friday, March 26, 1993, A6.

7. See, e.g., "Pain and Profit - A Special Report: Nursing Homes," The Charlotte Observer, September 27-30, 1992; "Nursing Home Profits Soar," Albany Times Union, October 7, 1992; "Nursing homes get $195 million more: Funding raised despite 100% hike in profits," Rochester Democrat and Chronicle, November 11, 1992; "Mining the Infirm-Some nursing home owners are putting your tax dollars to work by stuffing their families' pockets," "Medicaid - The gravy train -Reform misses the mark," The (Akron) Beacon Journal, (Two part series), July 19-20, 1992.

8. NSCLC has correspondence on file concerning nursing facility charges to private pay residents.

9. Comments of Peter Strauss at National Health Policy Forum on "Medicaid Spend-down and Asset Transfer: A Look Behind the Headlines," sponsored by George Washington University. Washington, D.C., March 20, 1992.

Mr. WAXMAN. Thank you very much as well.

You have all given us excellent testimony. This is a really troubling issue because we don't have a satisfactory answer to people who have played by the rules, who put a little money aside, and maybe even if they had wanted to buy long-term care insurance, have not had the opportunity to buy it because it just wasn't available.

Instead, what we say to these people is that they have to spend down in order to become eligible for some government assistance. We make them go through the demeaning process of impoverishing themselves. On the other hand, they sometimes go through the morally questionable process of impoverishing themselves only for the purpose of getting on Medicaid, leaving the nursing homes with less than what they might otherwise receive by way of reimbursement from people who could afford to pay a higher rate of reimbursement, and leaving the Medicaid program inadequately funded for other low-income patients.

Later today we are going to hear from the National Governors Association. They are going to testify that we should extend the current 30-month look-back period for the transfer of assets at less than fair market value. The NGA does not specify the amount of time this period should be extended. Some have argued it ought to be for 60 months. Let me ask each of you for your thoughts on that recommendation.

Ms. Nemore, I gather you would be opposed to that.

Ms. NEMORE. I think that the experience that we know of, and I think one of the earlier panelists alluded to it—how many Medicaid applications are denied for lack of information or incomplete information. To put a 60-month, a 5-year, look-back period where people have to basically bring every scrap of financial information from 5 years in their lives preceding application is going to result in an astronomical number of applications being denied for lack of information. It also reduces any kind of nexus between the need for long-term care and what is being looked at and really seriously interferes with how people live their lives and make decisions about other aspects of their lives. That is one proposal I think we would strongly oppose.

Mr. WAXMAN. OK.

Maybe we will just go right down the line. Mr. Chies.

Mr. CHIES. Mr. Chairman, we would support that provision.

Mr. WAXMAN. Mr. Goldberg.

Mr. GOLDBERG. Yes, we would support that proposal.

Mr. WAXMAN. Mr. Russo.

Mr. RUSSO. We would strongly oppose that proposal.

Mr. WAXMAN. Mr. Rohlfes.

Mr. ROHLFES. We would support the extension to 60 months, and let me give you an explanation of why this is. I attended a conference not too long ago that was sponsored by an elder law firm for a group of prospective clients, and one of the statements that was made there with respect to divestiture of assets and so forth was, they said a worst case scenario, a worst case situation, is, you will have to pay $90,000 for nursing home care, so that if you have a $5 million estate, for instance, we can protect all but $90,000.

The arithmetic that he explained for that $90,000 is that there is a 30-month look-back period in the Medicaid program and the average cost of nursing home care is about $3,000 a month. So if you multiply the $3,000 a month by 30 months, it comes to $90,000. So that is the maximum out of the $5 million that you would have to pay, and that is, in fact, how the existing 30-month look-back period is, indeed, being manipulated. So that is why we would be anxious to see it extended to something that more reasonably represents the period of stay that the taxpayers are paying for in nursing home care.

Mr. WAXMAN. Which would be?

Mr. ROHLFES. At least 60 months.

Mr. WAXMAN. Mr. Burwell.

Mr. BURWELL. Mr. Chairman, in the attachment to my testimony I made 16 specific recommendations for closing loopholes, but extending the look-back period was not one of them.

I have talked to States about this issue, and I get varied responses from States. Many States do believe that extending the look-back period beyond 30 months will incur administrative costs over and above what they would ever return from looking more than 2½ years back, going over financial transactions for that far back.

However, my general recommendation with regard to Medicaid estate planning is to allow States much greater discretion over these issues than they currently have rather than having to live within constraints of Federal Medicaid laws. So my recommendation is to allow States to make their own decisions about the look-back period.

Mr. WAXMAN. Let me just ask you about that. States have discretion now to do anything they want, as I understand the Medicaid law, to recover assets and to make sure that people are, in fact, eligible. The problem is, the States don't always decide to get involved in this area. So if you give States discretion, they just may find it politically so unattractive that they just won't act.

Mr. BURWELL. That is a legitimate point, but given the very feeling that I perceive from States, I would like to give them the discretion of how long a look-back period, perhaps giving them a minimum and a maximum.

I would like to point out, if some of the other recommendations included in my testimony are adopted, such as applying the penalty period from the date on which an individual would otherwise have been eligible and allowing the penalty period itself to extend beyond 30 months if the value of the assets transferred is over 30 months of private care, I think the need for extending the look-back period beyond 30 months is lessened.

Mr. WAXMAN. Thank you.

Let me indicate, Mr. Burwell sets forth 16 specific recommendations for closing loopholes he perceives in current Medicaid eligibility law.

Mr. Russo, I know this is the first opportunity you have had to review his list, and I don't even know if you have had a chance to do it at all. I would like to have your comments about those suggestions for the record. You don't have to respond to them now, but let me ask you to give us an initial reaction to one of these recommendations, that any inter vivos trust from which an applicant has transferred assets within 30 months of applying for Medicaid, regardless of whether the trust is discretionary or nondiscretionary, revocable or irrevocable, is null and void and the resources in the trust are considered immediately available to the applicant. What is your view on this use of Federal preemption power?

Mr. RUSSO. First of all, we would oppose such a provision, and I think we need to break down the points that are in this proposal. First of all, discretionary trusts and revocable trusts are already covered under the existing law. The Medicaid qualifying trust law under COBRA would tell us that if it was revocable or discretionary those assets in the trust would be an available resource for purposes of Medicaid eligibility.

Mr. WAXMAN. That is now the law.

Mr. RUSSO. That is correct, so I don't think we need to change there.

When we look at irrevocable nondiscretionary trusts, then we have to kind of dissect what that means and what type of trust are we talking about.

First of all, when you set up an irrevocable trust, the transfer will be subject to the 30-month transfer penalty period.

Someone who is doing that is going to have to retain sufficient resources to privately pay through the 30 months. So it is not a situation where they are avoiding or getting around a 30-month transfer penalty period.

Number 2 is that if we void this type of trust, then what seniors may do is simply make an outright gift rather than setting up the trust and give those moneys out retaining sufficient amount to pay privately for 30 months. And what will happen if that occurs? It is going to cost the government more money.

Medicaid is going to pay a larger share, and the reason is if that trust is an income-only trust, a trust in which the income goes back to the Medicaid applicant, then that income will go to pay the nursing home for the 30-month period and beyond the 30-month period for as long as that resident is in the nursing home. That will reduce the cost of Medicaid. So we have a situation where I think we are going at this trust and the avoiding of these trusts and it doesn't make any sense because we are going to cost the government more money in doing this.

Mr. WAXMAN. I don't understand why it is going to cost the government more money.

Mr. RUSSO. Because if the test is set up as the discretion of income, then the income must be used to pay the nursing home under the Medicaid qualifying trust law. What we are going to do is tell seniors give it away. Pay for 30 months and give the rest of it away; when we would rather say to them, pay your share of the cost of the nursing home and that share may well be your income coming out of that trust for the rest of your life. And if that income is going to pay for that care, then Medicaid is going to pay for less.

I would not propose such a provision here, because I think it is harmful and goes against public policy.

Mr. WAXMAN. To be fair, let me have Mr. Burwell respond.

Mr. BURWELL. I would like to make two points. Again, some of my recommendations are overlapping, so the same issue applies. If Mr. Russo is correct, a penalty period is applied for assets that are transferred to an irrevocable trust. If we make the change that that penalty period begins on the date that the person would otherwise be eligible for Medicaid rather than allowing people to have the penalty period begin on the date of the transfer, which may be well before they apply for Medicaid, and we extend the penalty period beyond 30 months whatever the value, if it was $500,000, the penalty period would extend for the amount of private care that that $500,000 would have paid for. We would not need this additional change in Medicaid law.

The other point I would like to make, if we extend Mr. Russo's logic to all assets held by seniors, he is advocating a public policy in that every senior ought to be allowed to buy an annuity with their assets rather than to use them to pay privately for their care and that would save the Medicaid program money. I doubt if that would be true.

Mr. WAXMAN. How do you deal with the assertion that if you eliminate this ability to transfer to any kind of trust they will just give away the money?

Mr. BURWELL. That may well be true. I mean, I believe that if we are going to close eligibility loopholes we are not going to do the job if we only close two or three. It has to be a comprehensive policy to address these loopholes. We cannot close one and let others open.

Mr. WAXMAN. I am going to come back to that on another round.

Mr. RUSSO. Can I respond to that. Loopholes—we are talking about loopholes or alleged loopholes. What we are talking about is punishing a very small percentage of the population who have very limited assets. And we hear stories about $500,000 estates——

Mr. WAXMAN. Obviously, there is a limit. But some of these people have pretty substantial amounts of assets that they are sheltering so that it will be passed on to the kids.

Mr. RUSSO. But I will share with you my experience in my practice. It is simply not happening. I don't have millionaires walking into my office saying I want to do advanced Medicaid planning. It is not happening. If they do come in, if they should come in, then it is not going to make sense for them to do Medicaid planning. It is an irrational response to dealing with protection of assets.

Mr. WAXMAN. $100,000? $200,000? Maybe those are not millionaires but those are substantial amounts of money that people will want to protect. So they will come to you to make sure that mom and pop don't use up that money. Isn't that correct?

Mr. RUSSO. Let's go to who are the people in nursing homes. They are 75 years of age or older, from Mr. Burwell's earlier report. The average person—the median wealth of a senior citizen is $75,000. Take their house out, it is $22,000. Those are the people who are looking to Medicaid for assistance. If we take—so we ought to be focused that when we lengthen penalty periods we penalize those people because they are going to fall into a trap administratively, providing documentation, all sorts of problems that are going to occur for that small population base.

Now, let's go to the seniors $100,000 or so, and I can only do this from my own personal experience in my practice. Nursing homes on Long Island, N.Y., are costing $70,000 to $80,000 a year. If someone has $100,000 and they have a spouse and they are $40,000 over the community spouse resource amount, and they want to protect that money which at 3 percent interest is going to generate $1,200 or an extra $100 a month for them to pay for necessary living expenses, I don't think that is a loophole. I think that person is looking to plan and protect that extra money, needs to do that under the current system.

We have got to look at the broader picture, which is we need a comprehensive long-term care system.

Mr. WAXMAN. You are absolutely right, but we don't have that system. And as sympathetic as these cases are, there are cases that are even more sympathetic of people who are going to be denied care, people below the poverty line, mothers and children that don't get care because the Medicaid program cannot afford it. So we are faced with a dilemma.

Is this simply another tax loophole that people should be able to get around to be comfortable themselves, or is this a program that they really shouldn't be taking advantage of, even there is not something else available? I won't ask for your position, but I understand what you are saying. These are sympathetic people.

I guess the dilemma that we also have if we try to figure out some way to deal with this is that all we are doing is starting another round of gaming and avoiding the Medicaid rules. Is there ever an end to it?

Mr. ROHLFES. I don't think so.

Mr. WAXMAN. There is never an end to it. There is some way lawyers, families will try to figure out a way around it.

Mr. GOLDBERG. My only comment is that it has become pop culture when you have home videos on the process of this thing. I think the issue is a issue of credibility and any dollar that flows out it really takes a dollar from someone who is most deserving and that is really what motivates us at this point.

Mr. WAXMAN. When you have a patient in one of your homes, Mr. Goldberg, or Mr. Chies, that is eligible for Medicaid, are they treated differently than a private patient?

Mr. GOLDBERG. To my knowledge, no, absolutely not.

Mr. WAXMAN. Mr. Chies, you don't have separate wings for Medicaid patients?

Mr. CHIES. No.

Ms. NEMORE. There is tremendous manipulation of the participation in the Medicaid program? We hear more so than ever before, in fact, under the nursing home reform law, we hear of nursing homes having Medicaid wings, Medicaid sections. And now by some administrative—or some administrative regulations, the facilities are permitted to do this and to actually separate their private pay and their Medicaid populations in a way that hasn't at all been clearly permitted in the past, although it has gone on, and it is a very serious problem. And I think that partly, Mr. Goldberg, has held up this video and Mr. Burwell has detailed this incredible number of practices that are available, but I think, as Mr. Russo points out, you have to think about the practical effects of any one of these.

There is a certain amount of intellectual gymnastics that goes on with this law because you can think of all sorts of ways to do things and are there, in fact, a lot of different ways to do a lot of different things. But people need to consider the practical consequences of it. People do, in fact, lose control and choices if they give away all their money. They may be impoverished, but you can lose your Medicaid bed in a facility and not get another Medicaid bed because we are now apparently allowing nursing homes to say we have certain beds certified for Medicaid.

Mr. WAXMAN. Why would they lose their bed?

Ms. NEMORE. People might lose their bed for going to the hospital and not being readmitted. People might be on Medicare. There is a great deal of complexity between the Medicaid and Medicare programs in nursing homes and who pays and what your status is considered because of who pays and if you come out of a hospital you are on Medicare, and therefore you don't fit within the Medicaid protections and people are moved around a great deal. So, in fact, by giving up wealth, people give up a tremendous amount of choice in how they get their long-term care. And this has to be part of their planning and of their consideration of what the options really are available to them.

Mr. WAXMAN. I assume if they are trying to get into a nursing home and they are on Medicaid, it is harder for them to get in.

Ms. NEMORE. It is much more difficult. And, in fact, the 30-month transfer provides almost an automatic private pay period that there is 2½ years that people will pay privately and get into the nursing home. And that, unfortunately, is more beneficial to them because they have greater choices to get in that way.

Mr. WAXMAN. Yes, Mr. Russo.

Mr. RUSSO. Can I pick up on a point with the 30 months? Our situation in New York is such that if you are—if you are in a hospital you need nursing home care and you are Medicaid-eligible and you file an application, you are Medicaid-pending and we cannot find a nursing home to take that individual out of the hospital. It is extremely difficult. No nursing home will take them. Why? Because it may take 6, 9, or 12 months to get an application approved and the nursing home has to run a business and they have no money coming in to pay for it and they don't know whether at the end that person is going to be approved or not.

Creating a longer penalty period is going to create more delays that would further penalize individuals and they are going to be forced to stay in hospitals, which is another cost that is being relayed back to the government. That doesn't make sense.

Mr. WAXMAN. I don't hear that from the nursing home operators. They are not worried about it. Mr. Chies or Mr. Goldberg, I would think you would be objecting to this if you found that you had to take patients without knowing whether you are going to get paid.

Mr. CHIES. I would disagree with Ms. Nemore about discriminating against Medicaid or Medicare patients. I think the OBRA 1987 amendments are severe about limiting discharges and transfers.

Mr. WAXMAN. Transfers or discharges, but how about entry?

Mr. CHIES. Discrimination as to entry also.

Mr. WAXMAN. Is it your testimony that the nursing home will take a Medicaid applicant as soon as they will take a private pay applicant?

Mr. CHIES. In my facility they will.

Mr. WAXMAN. Are you saying that you don't have the ability to make a choice between someone who is going to pay a higher rate and someone who is going to have the government pay?

Mr. CHIES. In Minnesota we have a different way in that the private rate is the same as the government rate.

Mr. GOLDBERG. Minnesota has a program called the equalization. They have the most substantial rates. I have to be candid with you and as in running any program, there is no charity if you impoverish yourself and you go bankrupt. A nursing home has to maintain some level of balance. I represent very few homes, if any, where Medicaid pays the actual cost of care.

Mr. WAXMAN. You represent very few homes that——

Mr. GOLDBERG. Very few providers who find that Medicaid is adequate to cover the care. Little Sisters of Charity in Detroit went out of business because they found out that the Medicaid program was not adequate to cover the cost of care and so they went out of business.

Mr. WAXMAN. Therefore, if someone comes to you and you have one bed available and one is going to privately pay and the other is not, I assume you are going to say I will take the privately paying customer because that helps subsidize the others?

Mr. GOLDBERG. I don't think it is as straightforward as that, but I do think homes pay attention to their ability to meet the needs of care. That is not in Minnesota.

Mr. WAXMAN. But it is hard for me to believe that the operators of an institution wouldn't think about such things when they know that they are not going to get full reimbursement of their costs. That seems to me the human reaction, unfortunately, just as it is to avoid paying for the Medicaid costs by shifting assets.

Mr. GOLDBERG. I can tell you that they do. I represent nonprofit providers and that is part of their commission. I can cite for you case after case that they see the need. That is not to say that they will impoverish themselves, but it does happen.

Mr. BURWELL. I would like to make three points. I do not believe that it is fruitless for us to attempt to close some of these loopholes and just others will be found. I don't want the committee to go away with the feeling that they are better off not doing anything because no matter what we do, will not have an effect.

Mr. WAXMAN. Say that again. You don't believe what?

Mr. BURWELL. I do not believe that we can adopt policies that will effectively prevent the estate Medicaid planning that is going on.

Mr. WAXMAN. You can make it harder.

Mr. BURWELL. You can make it much more difficult. The loopholes are so easy. Even if we don't do three or four things we can make it much more difficult. I have talked with many Medicaid estate planning attorneys and I do not know what Mr. Russo's practice looks like, but the ones that I have talked to said that the general net worth of their clientele is generally between $200,000 and $400,000. It is not the person with the $30,000 nest egg who seeks, you know, financial planning advice. They do not operate in those types of circles.

You see the most gross evidence of Medicaid estate planning, not in middle class areas, but upper income, relatively wealthy suburbs where people have access to this type of information.

Even though I make the point that I think it is atrocious that we have a system here in which the people's best decision is to divest of their assets, manipulate the system, do something which they do not feel good about, go on a welfare program, what they get at the end may not be in their best interest. I think it is an atrocious policy and people ought to be given a better alternative.

Mr. WAXMAN. I gather from your own experience when you go out and try to police this, some of the people who get caught you said are more sympathetic than some of those that were clever enough to get away.

Mr. ROHLFES. That is correct, unfortunately. From our standpoint we don't come into the case until it is all over with. So at the point in time when we come in and we enter the case, we are looking at history. And there is no recourse. All we can do is determine whether or not we can assert a claim under the law.

So all of the events that took place to divert assets and so forth are all over with and all we can do is have our own feelings as to the equity of those and then carry out the law as best as it exists at this point in time.

Mr. WAXMAN. I certainly see how one would be sympathetic to human circumstances of families trying to deal with this problem, and even those that have divested themselves of assets to qualify for nursing home coverage. Obviously, if there is a surviving spouse, that immediately raises the question of justice for that person who is going to be left penniless or with the meager amount that we provided in the past legislation of this. But still, if they had a lot of money to start with, the spouse is going to be left with quite little.

It is a dilemma, but let me ask this question of this panel: We exempt the homes in most States with the idea that the surviving spouse ought to be able to live in the home. We shouldn't tell someone at a nursing facility that their home is going to be taken out from under them because sometimes they are going to return home. But what if we were to put liens on homes and after the surviving spouse and any dependent relative has passed away, that there be a recovery for the money that was spent by the Medicaid program from the sale of that home? What do you think of that idea?

Mr. CHIES. Mr. Chairman, we support that provision.

Mr. GOLDBERG. We would support it with the caveat that you identified. You have to take care of the surviving spouse and dependent adult children. You would have to address that. And the home values have different values. Maybe there is some minimal level of exclusion for that, but homes in Washington could be hundreds of thousands of dollars and lower some place else. But we would support that concept.

Mr. ROHLFES. I am not an attorney, but I understand that under an existing Federal law that we can place a lien on a home when there is no intent to return home. However, in California we don't.

And the reason that we don't is under interpretation of California law, all a person has to do is say they intend to return home, and that precludes us from assessing a lien. And in some cases where the beneficiary is unable to say that they intend to return home because they are comatose and terminal, a conservator will make the statement that they intend to return home. And even that is adequate to prevent a lien. So something more than a lien. There needs to be something where the definition of intent to return home is made more specific.

Mr. WAXMAN. Under a new lien policy, the question of intent to return home would be irrelevant if the patient was in a nursing home if they, in fact, do not return home. After the surviving spouse and other dependents have passed on, then there would be a recovery against the property subject to the lien for the money spent by Medicaid on the individual in the nursing home.

Mr. ROHLFES. I would say that California would be supportive of any legislation which allowed the Medicaid agency more authority to assess liens against property.

Mr. WAXMAN. I think they can do that now, so it seems to me that the reason they are not doing it is because people would be outraged. Is that right Mr. Russo?

Mr. RUSSO. Absolutely. People are going to be outraged and there is a couple of reasons why. First, and I keep hitting it, but I feel compelled to do it.

Mr. WAXMAN. That is why you are here.

Mr. RUSSO. We are saying that we are going to take those people with Alzheimer's and those are the people's whose home we will take—Parkinson's, but not the person with the heart attack. There is something wrong with that up front. And, number two, the history of this country. Own a home, the American dream. In 1976, the Tax Reform Act, why did we go from an exemption to $600,000? To protect the home so that we could pass homes and farms to family members. So this would be so contrary to what our whole system has been telling the citizens of this country for the last 60 years. I only go back so many of them. It just does not make any sense. It would be very bad public policy.

And then you run into the situation, are you going to look for more gaming? Quote, unquote "gaming". If I am going to lose my home and it is not appropriate, then what do I do? Do I do Medicaid planning and make sure that I don't lose my home at the end? The solution is not going to be to have a recovery at the end for only those few who happen to require the long-term care. It doesn't make any sense. And I think the seniors would go absolutely crazy on this issue. I think they would be outraged.

Mr. WAXMAN. How about their adult children?

Mr. RUSSO. And their adult children.

Mr. GOLDBERG. Just one remark there. There is confusion on this issue and the interplay between Medicaid and Medicare and private pay. It demands, as we look at health care reform in this country, that we have to look at long-term care reform. And that is a plea to this committee.

Mr. WAXMAN. I am taking a long time with this panel, and I apologize, but this is an issue that has troubled me for a long time. I served on the Pepper Commission, which was instructed to resolve this problem of long-term care. And we looked at it and we said, we are going to resolve it by saying that we are going to try to provide more home health care.

Second, we said we are not going to require people to go through this indignity of impoverishing themselves. We are still going to require them to "spend down," but they will be able to retain more income, more assets. They wouldn't be reduced to the Medicaid level now. Those who want to pass on assets would buy insurance to pass on the assets to their heirs, and those that don't buy insurance will understand that they are going to use some of their money for their own protection and then the government would come in with a safety net that is more adequate.

What troubled me about that proposal is that I don't care what level we set as adequate, someone is going to be able to figure out that they ought to be able to keep as much as possible in the family, and we are still going to be at that same dilemma. Any responses to that?

Mr. ROHLFES. I just want to add one comment. As I understand it, the reason that a home is treated as an exempt asset is not because it is an asset but rather because it is the home. And the public policy, I think, is that we feel that it is better for people to have their own home and to keep that home than to divest that asset that they have and be forced to live somewhere else. But in the instant case that we are talking about here, these are people that are no longer in the home. They are in nursing homes and that home is no longer a home. It is an asset. And it should not enjoy that exemption any longer at that point in time.

But if the criteria for that determination is based on the statement, "intends to return home", and that intent is adduced, as it is, then we have this morass of confusion and inequity that takes place. I feel rather strongly that something needs to be done to clarify that intent to return so that the home is an exempt asset only when it is a home.

Ms. NEMORE. Mr. Chairman, I think there is some confusion about the home as an exempt asset versus the ability to put a lien on it and there are distinctions in the law currently between when it is exempt and when you can put a lien on it. And you can still put a lien on it and it remains exempt. And I think the issue that Mr. Rohlfes raises, when nobody is in the home, the point of the intent-to-return-home rule, I expect all of us, if we were ever in a nursing home would harbor in our hearts the desire to return home, and that is the idea that people should retain that desire, that there would be a place for them to go back to.

With the intent-to-return-home rule, there are practical considerations of how the home is kept up if, in fact, it is not lived in by a spouse or dependent children. So that, in itself, has somewhat of a self-policing mechanism. I think really the question more directly related to this concern is putting liens on the home and recovering from those liens.

Mr. WAXMAN. I understand your point. You are saying that you don't think there ought to be a lien against the home.

Ms. NEMORE. No, I am saying they are two separate things and we ought to retain the home exemption and that we should look to the lien law. I am not willing to say that we would support changes in the lien law, but we are certainly willing to consider them.

Mr. WAXMAN. That is my position, too.

Ms. NEMORE. There needs to be serious protections for people and safeguards and clear information available about what those safeguards might be. And I think I would probably support Mr. Goldberg's comment that there may be houses of some value that should be exempted from liens. For some poor people, the home is the family dream and it is a very modest one and it is the one thing that there may be to pass on. And there should be some consideration of that. And I certainly couldn't come up with a dollar value, but the concept of that should be considered.

Mr. WAXMAN. It is the American dream to own a home. But what we are talking about is the next generation that is not dependent on getting that home free and clear while the taxpayers pay for the owners of that home to get services as poverty cases. We are not talking about the issue of the family farm, which, of course, will be another objection to all of this. Yes, Mr. Burwell.

Mr. BURWELL. I agree this is a politically sensitive issue with regard to the treatment of the home. Mr. Rohlfes alluded to the Oregon program. Oregon has had a long-standing program to recover residential property from the estates of single nursing home residents, but, as well, tracking those claims, as long as exempted residents remain in the houses and the recovery in those Medicaid costs after the death or the sale of the property of those exempted relatives. And Oregonians do accept this as legitimate public policy.

This has been a long-standing policy in Oregon and it is not politically controversial. There is a creative program if the surviving spouse dies and there is a Medicaid claim on the home, the children can still own the home and essentially take a mortgage with the State at a reduced interest rate and pay back the Medicaid incurred cost over a period of time.

Mr. WAXMAN. Well, it sounds like a worthwhile model that you wonder why other States, almost all of whom are crying to us about the costs of their Medicaid program, have not decided to implement themselves.

Mr. BURWELL. I do think that Oregon's success in a political sense has to do with a long-standing culture and independence of people who live in Oregon and this has just been long-standing public policy.

Mr. WAXMAN. Sounds like it ought to change when more Californians move up there.

Mr. BURWELL. It well may, but I do think that the cultural and the long tradition does make a difference with regard to the politics of this.

Mr. RUSSO. I truly believe that seniors are willing to pay their fair share. And that is a tough one. Where do we draw the line on what is fair? If we can come up with options, alternatives that the seniors feel that they are paying their fair share, I think we can come up with some interim solutions. But I still think they are interim because ultimately as the demographics shift, we are going to fall into a huge hole. We are not going to come out of it; the Medicaid program.

Mr. WAXMAN. I proposed a long-term care bill that was going to be financed in part by higher inheritance taxes on big estates and the talk shows went nuts and people were calling and outraged at the idea that we would ask them to pay any higher taxes on their inheritances. So I just share with you the dilemma.

Mr. Towns, do you want to jump in this?

Mr. TOWNS. I think that when we look at what is going on in terms of nursing care in general, the fact that there is a two-tiered approach in many areas, and I think we have to admit that in some areas that if you are a private patient that things move a lot faster for you. If you are being discharged from a hospital and you can pay, that you move very quickly out of the hospital. However, if you have to get Medicaid clearance, then there is the possibility that you would have to stay a lot longer.

Don't we all acknowledge that? Isn't that the way things go? Anybody disagree with that?

Mr. GOLDBERG. I would disagree with that because I do represent a lot of providers and providers in New York City who work closely with hospitals and do work to get patients out as quickly as possible. We don't close our doors to people because they are backed up in hospitals. There is an issue of balance, of trying to keep our doors open economically and it is not easy, but our doors are open to people.

Mr. TOWNS. I just sort of have some problems understanding that, because you, you know, it is a business. And if you have three beds and you have three private patients, you know, waiting for the bed that can pay, and then you have three Medicaid patients, I would tell you that those private paying patients would probably move out a lot quicker even though they all need the service. This is what I have seen as I have moved around.

The other thing that I think—when you are talking about liens on property, I think that when you look at what is happening in this country in terms of the value of property, in terms of some areas in this country where a house—I had an experience some years ago at a certain area in the country, in Louisiana to be specific. I was down there and I saw a gorgeous home and I asked the person that was there for the commencement. I asked the person how much would a house like that cost, and he said to me that I could get that house for $125,000 in Louisiana in this particular area. And he asked me what it would cost me in New York. And I said it would probably be a down payment on the house in New York.

So when you start talking about liens on property and you start talking about paying for care, this is a very tricky area in terms of value of property. And the other part that I think we have to be sensitive to is that some people do return after going to the nursing home, do get out and do return back home or with a family member. And I think the thing that helps them the most is the fact that there is a house out there that they can go back to. I think that is very important. And when we move to take that away, I think that—I know you are talking about the Oregon program—but I think that in New York people would have problems with that in many, many ways because I think that is a form of motivation for people to sort of dream and to be able to get out.

Some will never be able to get out, but to be able to hold on to that is very important in terms of any type of rehabilitation, and to take that away from them, I think we have to be careful when we move in that direction. Comments?

Mr. ROHLFES. Can I respond to that question? If we are talking about a lien, a lien doesn't do anything to take the house away. And if a person in a nursing home is looking forward to recover and he does indeed recover and go home, that dissolves the lien and that is the end of it. The lien only protects the State's future claim in the event that the person doesn't return home.

Mr. TOWNS. Any time you have that with senior citizens in particular, the moment they hear that, they become very disturbed. Some things that they would want to avail themselves of, they would deny themselves of it because of the fact that they were aware of the fact that this would happen. So, you know, inasmuch as you are saying that it does not go all the way, but the point is that for people to know that if this happens to you, they will now put a lien on your property. And they will say, then I don't want this to happen to me and will fight it. And I think that is not good in terms of good public policy and good care. I think we should have it open where people are free to avail themselves of the service.

Mr. RUSSO. Just a couple of thoughts. One is that seniors do express to me that their biggest concern is losing their home. That is their major concern. And I think you are right that houses can vary in value dramatically around the country. And I think we have to put a time frame to it because most of them bought those homes 30, 40 plus years ago with their hard-earned savings and they have appreciated tremendously and that home does not generate income that helps them meet living expenses.

Mr. WAXMAN. Will the gentleman yield?

Mr. TOWNS. I will yield.

Mr. WAXMAN. They must be very happy when you tell them they are not going to lose their home, they can go to the nursing home and the home is going to be exempt. But obviously they say to you now, I have some other assets to protect because that is what you are advising them about. So it seems to me that if this is their number one concern and that is satisfied, then they want their number two, number three, and number four concern resolved. So if they have something, somebody else should pay for their care and not they and not their family.

Mr. RUSSO. I have to disagree with you respectfully on that. I have seniors who come in and will say to me, Medicaid—I am not going on Medicaid. I am going to spend every last nickel. You know we have all sorts of different people with different values and views as to what is going on here. And I don't think we can put these glossy statements that I have heard from other panel members about, you know, the millionaires all doing this planning and the wealthy.

I also would be amiss and I need to make this point, that as an elder law attorney, it is not the equivalent to Medicaid planning. Elder law attorneys are meeting the needs of seniors; right-to-die issues, housing issues, financial issues, guardianships, decisionmaking, advanced decisionmaking. So I don't think we want to equate elder law and Medicaid planning as one and the same.

It is a situation where, you know, we have got to give these seniors options that are rational. And I think if we can come up with good recommendations there, then we can work this out.

Mr. WAXMAN. What is rational for them—you are absolutely right, but what is rational for them becomes irrational for society because society then spends money for a poverty program, health care program, to take care of the elderly who could maybe pay for it even though they would rationally avoid it and justify it. And then we tell a lot of low income people who are below the poverty line, but not way below the poverty line that we don't have enough money to take care of their acute health care needs because the society can't afford it.

In the State of Oregon, interestingly enough, which has this program of estate recoveries they decided to ration health care for the lowest income women and children to provide health care for those who are also poor. It seems to me that it is wrong for the rest of society to ration services for low income women and children and deny them prenatal care and pediatric care and short change the future generation, in order to pay for nursing home care for the older generation, many of whom have assets of some amount, as modest as it may be, but nevertheless more than what would otherwise make them eligible for a poverty program. We are, in effect, giving them care and denying it to others.

Ms. NEMORE. Mr. Chairman, but the issue of the cost that we really should not allow ourselves to get into is the younger generation versus the older generation. It is really the issue of cost of long-term care. That is why the enormous cost of Medicaid is toward the elderly part of the population rather than the younger. It is because of the cost of long-term care largely. It is not because the person in Wisconsin wrote a check for $98,000. There are individual instances, but it is really the costs of long-term care itself that cause these enormous disparities.

Mr. WAXMAN. I understand, but if I presented to this committee the proposition of covering everybody right above the poverty line and putting them all on Medicaid, I couldn't get the votes for it because of the costs. And it is really not that expensive to take care of women and children as opposed to the costs of taking care of the elderly, but we avoid spending the money on the women and children because we are spending the money on caring for the elderly in nursing homes. We don't even spend it, for the most part, for home health care, and often for people who are not all that poor. It is a dilemma.

I thank the gentleman. I am going to be interested to see what the Clinton administration proposes to us in terms of specific recommendations in this area. And at some point I suspect they are going to have to give us some detailed recommendations on how to come up with the Medicaid savings they have requested.

I know Mr. Burwell has given us some. I am looking forward to reviewing them. I have not had a chance myself. Maybe the administration will look at your proposals and give us the same recommendations. But it is a frustrating dilemma for me and for all of us as we try to think this problem through. Any more?

Mr. TOWNS. I yield back. Move along.

Mr. WAXMAN. The gentleman's time has expired.

You have been helpful, all of you. I personally appreciate it because you are helping me think through this problem to no resolution, but one that may yet come to mind. Thank you very much for being with us.

[Testimony resumes on p. 453.]

[The following letter was submitted for the record:]

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April 15, 1993

The Honorable Henry A. Waxman, Chairman
U.S. House of Representatives
Committee on Energy and Commerce
Subcommittee on Health and the Environment
2415 Rayburn House Office Building
Washington, DC 20515-6118

Dear Congressman Waxman,

Thank you for your courtesy in inviting me to testify before your Subcommittee Hearing on Medicaid budget reconciliation held April 1, 1993.

Our response to your request for us to comment on Mr. Burwell's recommendations for Federal Legislation is enclosed. We have included in our response six proposals for Medicaid reform that we believe will result in fairness, simplicity and long term care cost reductions.

We appreciate your consideration that additional restrictions in the Medicaid program will further injure older persons who are already subject to a health care system that has not been effective.

We are available to you to answer any questions you have or to provide additional information, comments and any clarifications in the law.

Sincerely yours,

Vincent J. Russo

Vincent J. Russo, President
National Academy of Elder Law Attorneys

cc: Mr. Andreas Schneider, Esq.

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MEMORANDUM

TO: THE HONORABLE HENRY A. WAXMAN, CHAIRMAN, SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT

FROM: VINCENT J. RUSSO, PRESIDENT NATIONAL ACADEMY OF ELDER LAW ATTORNEYS

DATE: April 16, 1993

RE: BRIAN O. BURWELL --"RECOMMENDATIONS FOR FEDERAL LEGISLATION TO CLOSE MEDICAID ELIGIBILITY LOOPHOLES"

On behalf of NAELA, I appreciate having had the opportunity to testify before your subcommittee on the issue of Medicaid. NAELA understands that you have asked for our response to the recommendations of Brian O. Burwell.

NAELA fully appreciates that the administration's budget requires major cuts in Medicaid funding this year. However, NAELA believes that efforts to control costs should take into account the objectives of program simplicity, fairness in addition to long-term care cost reduction. Furthermore, sky-rocketing Medicaid costs are the result of escalating long term care costs. Such costs should be controlled by controlling provider costs rather than penalizing consumers.

The Burwell recommendations do not satisfy these objectives. They focus on areas in which abuse is perceived. Before commenting on the Burwell recommendations, NAELA suggests the following:

I. Proposals for Medicaid Reform

NAELA Proposal #1. Promote lower cost of care by allowing application of income and resource rules to apply to home care. This will lessen the economic incentives for nursing home placement.

- The current rules encourage premature institutionalization. This family tragedy is incurred at a high cost. It is less expensive to provide care for older persons in their homes and that is where most of the them prefer to be. In their own homes, older persons remain part of the community in the least restrictive environment. Current policy (MCCA) recognizes the value of supporting community spouses in their homes. This is an extension of that policy.

NAELA Proposal #2. Promote compliance by increasing the income standard for individuals residing in the community to a reasonable living standard.

- NAELA believes that it will be cost effective to increase the standard of living for individuals who live in the community and require Medicaid to pay for their health care.

NAELA PROPOSAL #3. Changes in the Medicaid law should not be retroactive such that individuals who have complied with the existing Medicaid law are harmed.

NAELA PROPOSAL #4. Establish consumer protection standards for long term care insurance.

- Standards for such insurance would provide uniformity, and tax incentives could then be explored.

NAELA Proposal #5. **Recognize court ordered support involving both Medicaid applicants and recipients.**

- **This allows for fairness through the judicial system on an individual basis.**

NAELA Proposal #6. Eliminate the income cap.

- Many of the states limit Medicaid qualification based upon income. These states are referred to as income cap states. Under this policy, seniors are arbitrarily and absolutely precluded from obtaining essential assistance even though their income is too little to pay for available nursing home care and there are no other options.
- The test for Medicaid qualification should be medical need where income and resources of the individual are otherwise inadequate.

II. **Responses to comments provided by** Brian O. Burwell (made at the Medicaid Budget Reconciliation Hearings before your Subcommittee on April 1, 1993.)

1. **Burwell Comment:** "Clarify that withdrawals of an applicants' resources from a joint bank account, even when made by non-applicants, is subject to Medicaid transfer of asset penalties. However, penalties should not be applied to withdrawals of funds originally deposited by non-applicants."

   NAELA Response: We support clarification of treatment of joint accounts for Medicaid so that ownership and transfer of assets provisions are applied.

   - Ownership for Medicaid eligibility purposes should be presumed proportionate to the number of joint tenants.

- Transfer of assets treatment should mirror the treatment of ownership.

  For example: creation of joint ownership in assets formerly owned by a person who is now an applicant would be presumed to be a transfer of assets to the extent of the proportionate share that no longer belongs to the applicant.

- The presumption of ownership should be rebuttable by evidence of actual ownership under state law.

- Eligibility would not be denied to a person who has a cause of action against a joint tenant who has withdrawn the applicant's share if the applicant assigns his or her rights of recovery to the state.

2. **Burwell Comment:** "Putting [real] property into joint tenancy, even if the Medicaid applicants retains ownership rights, should be treated as an illegal transfer if the act of placing the property in joint tenancy makes the resource unavailable to the applicant."

   NAELA Response: NAELA supports uniformity of law that regulates and defines how joint tenancy will be treated for Medicaid qualification.

   - The use of the term "illegal" in the comment is inappropriate. Transfers of assets are not "illegal" under the Medicaid program.

3. **Burwell Comment:** "The penalty period for prohibited asset transfers should begin on the day that the individual would have otherwise been eligible for Medicaid while receiving institutional care, not on the date of the transfer."

   NAELA Response: NAELA opposes this comment.

   * A general rule that prohibits all asset transfers is oppressive. The penalty period should run from the date of transfer.

   * A period of ineligibility that starts later would create greater pressures on individuals to transfer assets earlier in order to avoid a transfer penalty. If this happens, there will be no cost savings (and potential cost increases) to the Medicaid program. There may also be increased disruption and economic risk to individuals.

4. **Burwell Comment:** "Clarify that in computing the penalty period for illegal transfers, that penalty periods for multiple transfers do not run concurrently, but consecutively. This common practice has allowed applicants to divest significant amounts of assets, yet minimize the penalty period to which they are subject."

   NAELA Response: NAELA supports the intent of this comment.

5. **Burwell Comment:** "There should be no time limit on the length of the penalty period, which is currently 30 months. The penalty period should equal the value of the assets transferred for less than fair market value, without limitation. However, assets transferred more than 30 months prior to Medicaid application should remain exempt from Medicaid asset transfer rules. Most states believe that "looking back" more than 30 months for illegal transfers would not be cost-effective. [1]"

NAELA Response: NAELA opposes this comment.

* Lengthening the period of ineligibility (defined by Burwell as the penalty period in the comment above) for those who apply for Medicaid during period of ineligibility would penalize individuals who apply for Medicaid during such period. This would not similarly affect those who wait for the period to pass.

For example, if a person transfers assets and applies for Medicaid following a period of 30 months, such person will qualify for Medicaid. If, however, the same person applies during the period of ineligibility, he or she will ineligible -- possibly for many years, depending upon the value of the asset transferred. Such differentoutcomes should not result from essentially similar actions. The maximum penalty should not exceed the period of ineligibility.

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[1] Some states, however, believe that 'look back' period should be extended more than 30 months.

6. **Burwell Comment:** "Clarify that transfers of assets made by persons acting as agents of the applicant (guardians, conservators, persons authorized to make such dispositions under a power of attorney) are treated the same as if made by the Medicaid applicant/recipient."

   NAELA Response: NAELA supports this comment, excepting transfers ordered by a court and by victims of unauthorized transfers.

7. **Burwell Comment:** "Clarify that transfers of lump sum payments, such as inheritances, that are made in the month in which they are received, are to be treated as transfers of assets, and therefore subject to penalties, and are not considered transfers of income."

   NAELA Response: NAELA opposes this comment. It conflicts with mandatory SSI asset and income rules.

   * Medicaid rules on treatment of assets and income may be no more restrictive than the comparable treatment under the SSI program. Supplemental Security Income treats lump sums received as income during the month received; the receipt does not take on the character of a resource until the beginning of the next calendar month.

8. **Burwell Comments:** "Clarify that disclaimers of inheritances or other lump sum payments, such as court settlements, are to be treated as asset transfers, subject to penalties."

NAELA Response: NAELA opposes this comment.

* This is a substantive policy change inconsistent with settled common law and statutory rules relating to renunciation and disclaimers. Courts should remain free to apply state law.

9. **Burwell Comment:** "Limit the amount of funds that can be placed in an irrevocable funeral contract, not subject to penalties, to $1,500, or some other reasonable amount."

NAELA Response: NAELA opposes this comment. It conflicts with mandatory application of SSI asset exemption rules.

* Medicaid rules on treatment of assets may be no more restrictive than the comparable treatment under the SSI program. Supplemental Security Income permits up to $2,000 to be place in an irrevocable funeral contract, and allows an unlimited amount to be set aside for burial spaces and burial space items.

* Neither $1,500 nor $2,000 is a reasonable amount. Since the cost of burial may vary significantly from community to community, the law should allow flexibility to accommodate these variations.

* If an inadequate amount is reserved for funeral and burial, the cost may be borne by the state.

10. **Burwell Comment:** "Stipulate that any inter vivos trust to which an applicant has transferred assets within 30 months of applying for Medicaid, regardless of whether the trust is discretionary or non-discretionary, revocable or irrevocable, is null and void, and the resources in the trust are considered immediately available to the applicant. Congress may wish to exempt, however, certain "supplemental needs" trusts created for severely disabled individuals, the income from which is used to purchase necessary equipment and/or services, not available under the regular Medicaid benefit package, for the maintenance of the disabled individual."

NAELA Response: NAELA opposes this comment, except for its approval of supplemental needs trusts benefiting the disabled including older Americans and children.

* Medicaid rules on treatment of assets may be no more restrictive than the comparable treatment under the SSI program. Supplemental Security Income rules state that no assets in an irrevocable trust are treated as available, and that the assets of a revocable trust are only available if the applicant is able to revoke the trust.

* The comment disrupts settled law of trusts. Other areas of law, including tax law, respect the integrity of valid trusts.

* The transfer of assets rules already address trust questions by imposing a period of ineligibility for any transfer to an irrevocable trust made within 30 months from date of Medicaid application. In addition, any trust distribution or right to receive income or principle is counted as available under Medicaid rules.

- The Medicaid Qualifying Trust rules already limit the use of grantor trusts for Medicaid planning purposes (COBRA 1985).

11. **Burwell Comment:** "Clarify that while certain types of 'income trust' may be used as mechanisms for allowing certain individuals to qualify for Medicaid nursing home coverage in so-called "income cap" states in accordance with the Federal district court ruling in Miller vs. Ibarra, allow states to impose conditions on the creation and use of such trusts, as recently done in the state of Colorado."

NAELA Response: NAELA supports this comment in concept, however, we believe that there should be no income cap.

- NAELA agrees that the use of income trusts as mechanisms for allowing certain individuals to quality for Medicaid nursing home care is responsible. States should not be allowed to impose conditions on the creation and use of such trusts.

- NAELA further recommends that any legislation in this area should be extended to home and community based services and hospitals, as well as to nursing homes.

12. **Burwell Comment:** "Clarify that retroactive payments for "care" provided by relatives do not constitute "fair market value" for transferred assets. Prospective payments, however, can be made, as long as they are made under a written agreement, and the payments made represent reasonable compensation for the care or services provided."

NAELA Response: NAELA supports this comment as restated below.

- Regulations should be developed to provide standards for evaluating whether payments to relatives for care represent reasonable compensation for services. Written agreements unfairly anticipate sophistication and pre-planning. Home based health care should anticipate fair compensation of family care givers.

13. **Burwell Comment:** "Allow states to apply transfer of asset penalties to that portion of a purchased annuity that exceeds the value of the benefit that is likely to be returned to the annuitant over his or her remaining life expectancy, using life expectancy tables."

NAELA Response: NAELA supports this comment, and recommends the use of IRS tables for determining life expectancy.

- Notice and disclaimer addressing transfer penalties should be required on all annuities.

- Qualified plans subject to ERISA require annuity based payments to surviving spouses. The comment is inconsistent with this ERISA policy enacted to address the spousal impoverishment (concerns also raised in MCCA.)

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14. **Burwell Comment:** "Clarify that in the determination of the Community Spouse Resource Allowance (CSRA) under the Medicaid spousal impoverishment rules, the income of the institutionalized spouse must be made available to the community spouse prior to determining whether the community spouse's CSRA should be increased in order to generate sufficient income to meet the Minimum Monthly Maintenance Needs Allowance (MMMNA)."

NAELA Response: NAELA opposes this comment.

- The proposed rule leaves the community spouse vulnerable, where the institutionalized spouse has income that will terminate or be significantly reduced when the institutionalized spouse dies.
- The income that the community spouse derives from resources is much more likely to keep up with inflation than the income from the institutionalized spouse. Limiting the community spouse to income allocation from the other spouse threatens his or her economic security.
- The recommendation may increase Medicaid costs. If the community spouse is forced to rely solely on income allocation, the monthly cost to the state for the institutionalized spouse, will increase. If the community spouse is entitled to retain assets to produce the necessary Minimum Monthly Maintenance Needs Allowance (MMMNA), institutionalized spouse's income would not need to be allocated to the community spouse. This alternative may save costs to the Medicaid program.

15. **Burwell Comment:** "Clarify that states may impose a lien on the home of a community spouse (or other exempted relative) of an institutionalized Medicaid recipient [during the life of the institutionalized spouse] , even though states may not foreclose on the lien until the community spouse dies or sells the property."

NAELA Response: NAELA opposes this comment.

* The satisfaction of a lien upon sale in order to clear title will deprive the community spouse of the proceeds needed to purchase a replacement residence if he or she moves. The lien during the lifetime of the community spouse would make transactions (e.g. home equity loans, reverse mortgages, and home improvement loans) during the spouse's lifetime burdensome.

* Since the amount of the lien cannot be satisfied, it increases during the time that the Medicaid recipient receives benefits. The proposal would create an incentive for the community spouse to sell the residence as soon as possible after Medicaid eligibility is established in order to stop accrual of the obligation under the lien.

* The recommendation runs contrary to the public policy of the states to provide a protected homestead for homeowners.

* For many properties, the state would become the major stake-holder. Properties would go untended and fall into disrepair as survivors and heirs realized that they no longer have a financial stake in the value of the property (e.g. Resolution Trust Corporation foreclosures illustrate this). States are ill-equipped to develop efficient foreclosure mechanisms to prevent property from devaluing and becoming a community problem.

16. **Burwell Comment:** "Clarify that although term life insurance policies remain an exempt resource in most cases, certain term policies are not exempt. Specifically, resources used to purchase term life insurance policies within 30 months of Medicaid application that have a benefit-to-premium ratio in excess of certain standard would be considered available, and not exempted. For example, a term life insurance policy with a death benefit of $100,000 purchased by an 89-year-old man for the price of $97,000 would not be exempted."

NAELA Response: NAELA supports this concept; however it raises practical concerns.

* Medicaid rules can be no more restrictive than Supplemental Security Income rules. SSI does not count term life insurance as a resource.

* NAELA is not aware of seniors abusing the purchase of term life insurance in the context of Medicaid qualification.

III. Conclusion

NAELA appreciates the opportunity to present this response and to furnish to the Subcommittee its proposals for Medicaid Reform. Our objective is to promote simplicity, fairness and cost reduction.

We have not provided an appendix of resources. We are available to furnish such resources and comments as the Subcommittee may request.

Mr. WAXMAN. Our next panel, instead of lunch, will address the administration's proposal to remove the current prohibition against the use of drug formularies by the States. Until OBRA 90, States had a flexibility to use formularies. That year, in response to a budget reconciliation directive, we required all manufacturers to give rebates on their products in order to receive immediate Federal Medicaid matching funds on the products.

In exchange, States that elected to cover prescription drugs would have to cover all products on which rebates are available.

Last year we extended this government-industry compact to other Federal purchasers. Under the Veteran's Health Act manufacturers cannot receive Medicaid payments on their products unless they offer rebates not just to Medicaid, but to the Department of Veterans Affairs, the Department of Defense, the Public Health Service, the Indian Health Service and federally-funded community centers.

The administration now proposes to revisit this agreement and allow the States to limit the drugs they will cover even though rebates are available.

Donald Herman is administrator of the Division of Medical Services of the Iowa Department of Human Services. Abbey Meyers is the Executive Director of the National Organization for Rare Diseases. Robert Allnutt is Executive Vice-President of the Pharmaceutical Manufacturers Association. Dee Fensterer is President of the Generic Pharmaceutical Industry Association. Dr. Richard Butcher represents the National Medical Association.

We are pleased to welcome you. Without objection, your prepared statements will be inserted in the record in full. We would like to ask you to limit your oral presentation to no more than 5 minutes.

Mr. Herman?

STATEMENTS OF DONALD W. HERMAN, MEDICAID DIRECTOR, IOWA DEPARTMENT OF HUMAN SERVICES; ABBEY S. MEYERS, EXECUTIVE DIRECTOR, NATIONAL ORGANIZATION FOR RARE DISORDERS; ROBERT F. ALLNUTT, EXECUTIVE VICE PRESIDENT, PHARMACEUTICAL MANUFACTURERS ASSOCIATION; DEE FENSTERER, PRESIDENT, GENERIC PHARMACEUTICAL INDUSTRY ASSOCIATION; AND RICHARD O. BUTCHER, PRESIDENT, NATIONAL MEDICAL ASSOCIATION

Mr. HERMAN. Mr. Chairman, my written testimony was faxed in from Iowa earlier last week. Late yesterday it was discovered that several pages had not arrived. We have obtained those pages and the subcommittee's copies have been updated.

Mr. Chairman, Mr. Towns, my name is Don Herman. I am Medicaid Director for the State of Iowa. I am a member of the Executive Committee of the State Medicaid Directors Association and I chair the AMDA Technical Advisory Group on Formulary Reform.

I appreciate being asked to speak to you about the use of drug formularies in the Medicaid program. First, please allow me to take a few minutes to give you numbers background on Iowa's program. When our fiscal year ends on June 30 we will have spent $990 million on behalf of 225,000 different persons. This will be a 15 percent increase in expenditures over fiscal year 1992.

Expenditures for prescription drugs will be $80 million, representing 8 percent of total expenditures. Rebates mandated by OBRA 90 will adjust this by some $10 million. When we look at the increase in cost per unit only, we find the greatest increase occurring in prescription drugs.

Here our cost per unit is increasing at a rate of 13 percent. A closer examination of that increase reveals that it is virtually all attributable to the product component. We have not increased our dispensing fees since July 1 of 1990.

This ever-escalating cost of drugs, as well as the instruction of new, expensive biotech drugs precipitated in the OBRA 90 legislation mandating drug rebates to State Medicaid programs. At the same time, this legislation prohibited States from maintaining drug formularies. Prohibiting the use of the formulary was a costly decision for those States that had one in place depending, of course, on how it was being used.

Iowa has not used a formulary, but with Alabama Medicaid's permission I have included their experience upon discontinuing their formulary.

A drug formulary is an option which States should be allowed to utilize. It should not, I hasten to add, be on the condition of a trade-off with a rebate program or well-constructed programs of prior authorization. A formulary my be defined as a compilation of pharmaceutical and related products sanctioned for patient treatment in a given delivery or contractual situation. It may also be defined as preferred therapeutic agents that health care providers are encouraged to use to maximize patient outcomes.

A formulary may be open or voluntary; closed or mandatory; or incentive-based requiring beneficiaries to pay more for nonformulary choices. In the past under Medicaid programs the term "formulary" was frequently used to identify the list of drugs for reimbursement. Drugs covered by the State for treatment were termed "positive formularies," and those drugs that were excluded from reimbursement were termed, "negative formularies."

A drug formulary must be a dynamic tool which can be continually evaluated and responsive to changes in drug therapy.

The primary objective of a drug formulary is to promote rational use of prescription medications. In order to accomplish this, the formulary would reflect the practice of medicine in the community, be responsive to the needs of health care providers and represent cost-effective therapy.

The selection of a medication to a formulary list should focus on patient care, clinical efficiency and then total cost. Formularies are developed due to the large number of therapeutic options or "me too" drugs which represent therapeutic agents that have little or no therapeutic advantage over medications currently on the market.

To assist health care providers in prescribing more efficiently, clinicians need comparative data which could indicate what medications are most likely to maximize the positive outcome of the patient being treated.

A pharmacy and therapeutics committee generally operates as a formulary advisory committee. This is a process where pharmacists and physicians are brought together to make decisions about the value of medications and the improvement of quality patient care.

These two unique groups must be allowed to have input into any formulary decision due to the drug knowledge base and expertise of the pharmacist and disease State/diagnostic expertise of the physician.

The formulary process is not new and has been used successfully in hospitals and managed care programs. Formulary decisions made by pharmacists and physicians are common sense judgments that are good medicine. The P&T committee should meet several times a year to evaluate medications on efficacy, safety, side effects, drug-to-drug interactions dosage and cost-benefit ratios. All States are now required to have in place a drug utilization review board whose scope of responsibility could include the P&T committee function and activity.

The utilization of a formulary brings recognition to the three major groups affected by a formulary. The pharmacists clinical role can be further recognized in patient care and by acting as a gate keeper. The physician with comparative information available can be encouraged to modify patterns of prescribing. And patients are urged to discuss their prescriptions with their pharmacists and physician.

In closing, Mr. Chairman, I would encourage you to consider the administration's proposal to remove the prohibition on formularies, but to have in place certain safeguards to ensure that access is not denied on an arbitrary basis. This could be structured so that at least one drug in every therapeutic class is covered and that if any other drug in the same class is deemed necessary for treatment by the physician, that mechanisms be in place for that request to be processed promptly.

A formulary that provides flexibility, cost-effectiveness, justification, drug use protocols and monitoring tools stressing education and information can provide for an appropriate role of prescription therapy in patient care. Thank you.

[The prepared statement of Mr. Herman follows:]

STATEMENT OF DONALD W. HERMAN, IOWA DEPARTMENT OF HUMAN SERVICES

Mr. Chairman, members of the committee, my name is Don Herman. I am Medicaid Director for the State of Iowa. I appreciate being asked to speak to you today about the use of drug formularies in the Medicaid program.

First, please allow me to take a few minutes of my time to give you some numbers background on Iowa's program. When our fiscal year ends on June 30 of this year, we will have spent nearly $990 million on behalf of 225,000 different persons. This will be a 15 percent increase in expenditures over fiscal year 1992. Expenditures for prescription drugs will be $80 million representing 8 percent of total expenditures. Rebates mandated by OBRA 90 will adjust this by some $10 million. When we look at the increase in cost per unit only, we find the greatest increase occurring in prescription drugs. Here our cost per unit is increasing at a rate of 13 percent.

A closer examination of that increase reveals that it is virtually all attributable to the product component. We have not increased our dispensing fee since July 1, 1990.

This ever escalating cost of drugs as well as the introduction of new expensive "biotech" drugs precipitated the OBRA 90 legislation mandating drug rebates to State Medicaid programs. At the same time this legislation prohibited States from maintaining drug formularies. Prohibiting the use of the formulary was a costly decision for those States that had one in place depending of course on how it was being used. For example, Alabama's Medicaid drug formulary was opened on May 1, 1991. For fiscal year 1990, the last full year of formulary utilization, expenditures for prescriptions amounted to $60 million. In fiscal year 1991 approximately $73 million was expended for prescriptions, a 21 percent increase over fiscal year 1990. Fiscal year 1992 approximately $97 million was expended for prescriptions, a 33 percent increase over fiscal year 1991. Projections for fiscal year 1993, utilizing year to date figures, reflect $126 million in prescription expenditures, a 30 percent increase over fiscal year 1992 (see Exhibit A.) While prior authorization programs are allowed, Medicaid agencies need as many options as possible to manage their drug programs in a cost effective manner. A drug formulary is an option which States should be allowed to utilize.

A formulary may be defined as a compilation of pharmaceutical and related products sanctioned for patient treatment in a given delivery or contractual situation. It may also be defined as a list of preferred therapeutic agents that health care providers are encouraged to use to maximize patient outcomes. A formulary may be "open", or voluntary; "closed", or mandatory; or "incentive based", requiring beneficiaries to pay more for non-formulary choices. In the past, under Medicaid programs, the term formulary was frequently used to identify the list of drugs for reimbursement, Drugs covered by the State for treatment were termed positive formularies, and those drugs that were excluded from reimbursement were termed negative formularies. A drug formulary must be a dynamic tool, which can be continually evaluated, and responsive to changes in drug therapy.

The primary objective of a drug formulary is to promote rational use of prescription medications. In order to accomplish this the formulary should reflect the practice of medicine in the community, be responsive to the needs of the health care providers, and represent cost-effective therapy. The selection of a medication to a formulary list should focus on patient care, clinical efficiency, and then total cost. Formularies are developed due to the large number of therapeutic options, or "me too" drugs, which represent therapeutic agents that have little or no therapeutic advantage over medications currently on the market, being made available for treatment. To assist health care providers in prescribing more efficiently, clinicians need comparative data which could indicate what medications are most likely to maximize the positive outcome of the patient being treated.

A pharmacy and therapeutics committee (P&T) generally operates as a formulary advisory committee. This is a process where pharmacists and physicians are brought together to make decisions about the value of medications and the improvement of quality patient care. These two unique groups must be allowed to have input into any formulary decision due to the drug knowledge base and expertise of the pharmacist and disease State/diagnostic expertise of the physician. The formulary process is not new and has been used successfully in hospitals and managed care programs. Formulary decisions made by pharmacists and physicians are common sense judgments that are good medicine. The P&T committee should meet several times a year to evaluate medications on efficacy, safety, side effects, drug-drug interactions, dosage and cost-benefit ratios. All States are now required to have in place a drug utilization review board, whose scope of responsibility could include the P&T Committee function and activity.

The utilization of a formulary brings recognition of the three major groups affected by a formulary. The pharmacists' clinical role can be further recognized in patient care and by acting as a gate keeper; the physician, with comparative information available, can be encouraged to modify patterns of prescribing; and patients are urged to discuss their prescriptions with their pharmacist and physician. Any formulary process should have support services for these groups: pharmacists (letters, updates, reports, newsletters); physicians (compliance reports and consulting programs); and patients (patient guides and mailings).

The formulary should not only be utilized for prescription drugs, but for over-the counter (OTC) medications as well. Over-the counter medications should be an integral part of the formulary as many OTC's can be used as drugs of choice for medical problems, and negative economic results may occur if excluded.

A formulary should be part of an overall integrated quality assurance program. A drug formulary and a drug utilization review program represent complimentary quality assurance techniques, and represents a method to maximize patient benefit and outcome. A formulary can assist a drug utilization review program by helping to answer whether or not the drug of choice was ordered for the medical problem treated.

There are, however, problems or concerns associated with the utilization of formularies. The administrative costs of a formulary can be substantial, due to the demand for regular review and updating. Mechanisms need to be in place, for the utilization of non-formulary medications, or for prescribing more than one agent concurrently. The potential for switching diagnoses to those for which prescription reimbursement is available ("diagnosis drift"), as well as switching among drug therapies, has been shown to increase overall expenditures. This is especially true in a restrictive formulary where access to advances in drug therapy is often denied. Therapeutic objectives can not be subservient to economic and administrative ends.

Therapeutic goals will seem compromised when implemented to solve economic problems. Procedural methods such as the method of nominating new medications, distributing formularies, and technical support have their own inherent challenges. Liability is another issue. Formulary decisions based solely on economic principles may have an organization subject to liability exposure. Negligence, determining standards of care, unlabeled uses, informed consent are but a few issues in the liability arena.

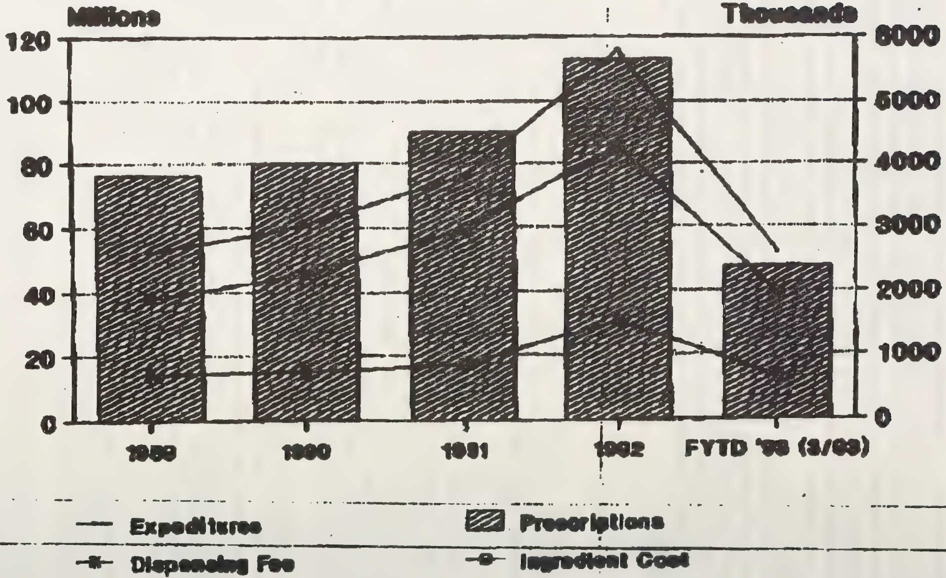
I would encourage you to have in place, in legislation, certain safeguards to assure that access is not denied on an arbitrary basis. This could be structured so that at least one drug in every therapeutic class is covered and that if any other drug in the same class is deemed necessary for treatment by the physician, that mechanisms be in place for that request to be processed promptly. A properly structured formulary system, that is one that is an integrated component of quality assurance, with a flexible plan design and drug utilization review, may achieve its purpose of rational drug prescribing, thereby reducing cost expenditures and producing cost-effective benefits without jeopardizing the standard of care now received by patients. Many patients today, including Medicare and Medicaid patients, are enrolled in managed care programs that utilize formulary systems and those patients do not receive substandard care. Through education of health care providers and patients, positive patient outcomes could be achieved without undermining the quality of care offered. A formulary that provides flexibility, cost-effectiveness justification, drug use protocols, and monitoring tools stressing education and information can provide for an appropriate role of prescription therapy in patient care.

Thank you.

EXHIBIT A

Alabama Medicaid Pharmacy Program

Pharmacy Program



Mr. WAXMAN. Thank you for your testimony. We are being summoned to the House Floor for a vote. We will take a 15-minute recess. We will reconvene at half past the hour and continue on with the testimony.

[Brief recess.]

Mr. WAXMAN. I would like to now call on for oral presentation, Mrs. Meyers

STATEMENT OF ABBEY S. MEYERS

Ms. MEYERS. Thank you, Mr. Waxman. Thank you very much for allowing me the opportunity to speak today. The National Organization for Rare Disorders represents 20 million Americans and 5,000 rare disorders which are known as orphan diseases. Historically we have also been opposed to formularies because people with rare diseases tend to take drugs that are not ordinarily on formularies or they tend to take drugs that are used for indications that are not listed on their labels. So in many States in the past people with rare diseases have had great difficulty obtaining unusual drugs that normal formularies did not have listed.

Yet we know that competition in the health care sector defies the free market system. Competence doesn't lower prices except in two areas: One is generic drugs and the other is formularies. We have seen formularies lower prices in hospital—for hospital drugs because companies have to bid against each other in order to get their drugs on the formulary. And now the President has asked us to make sacrifices in order to get a universal health care system that will be fair to everyone. And it seems to us that formularies would be the appropriate place to start.

If you have very strict guidelines in implementing, then NORD's main concern is that they should be responsive to patient needs, even the unusual needs of rare disease patients. And that is because of the old saying that many physicians have in university-affiliated hospitals. They say that normal hospitals admit many horses, but the zebras are sent to them. And if you look under the sheets of beds in any hospital, most people will be the horses, but there will always be a few zebras. So instead of patchwork of 50 Medicaid plans that all have the same rules, we think there has to be strict Federal guidelines and regulations.

The average patient is prescribed a drug, we believe, based on the marketing of this drug to the physician who writes the prescription. And really it is not based on medical superiority basically because there are very few studies comparing one drug to another to see which one is truly better than the other. Formularies should be based on price and medical superiority for common health conditions. There is no reason that every arthritis drug and hypertension drug should be listed. And in many cases it should be based on price. But not every patient will respond to a limited number of drugs as formularies and this raises the question of who are the zebras.

The zebras are rare disease patients or patients who may be allergic to the drugs on the formularies or nonresponders or people who can't tolerate the drugs because of side effects. The formularies, in other words, must be flexible. We believe that all formularies must contain the break through drugs, even if they are not widely used, when there is no similar drug in that therapeutic category. Nonformulary items should be requested by doctors and the doctors should be given an answer within 24 hours.

In any delay in a decision, the patient should be given a temporary supply immediately until the doctor's request is reviewed. And they should not have to put in this request every month. It should be every 6 months or every year.

For some reason it shouldn't even be reviewed if a person has a chronic illness. For serious and life-threatening diseases there should be absolutely no delay in obtaining a nonformulary drug. Offlabel uses must be covered. This is essential because many drugs are labeled for prevalent diseases and there is no economic reason for a company to invest in the research to get it relabeled for rare diseases.

My own children, for instance, take a high blood pressure drug for treatment of Tourette Syndrome. It has nothing to do with their blood pressure. It is a neurological disorder. It would be awful to have these people not treated because the drug is not labeled for it. You could use the Medicare criteria for offlabel uses which is the three compendia because the review of peer reviewed medical literature.

Also, please, if you can do anything immediately, eliminate the ability of States to limit the amounts of prescriptions a patient can have under Medicaid. The State of Texas allows only three prescriptions per month; North Carolina five prescriptions per month. Probably your mother or father is on 8 or 10 prescriptions per month. This is just inhuman.

So in summary, will formularies save money? Yes, they will, but in the zeal to reduce costs, please don't forget the zebras.

[The prepared statement of Ms. Meyers follows:]

STATEMENT OF ABBEY S. MEYERS, EXECUTIVE DIRECTOR, NATIONAL ORGANIZATION FOR RARE DISORDERS

Mr. Chairman, members of the committee, I am Abbey Meyers, Executive Director of the National Organization for Rare Disorders (NORD). We sincerely appreciate that this hearing is being held to examine the question of whether the Federal Government should allow State Medicaid systems to institute drug formularies. It is obvious that the government must do something to inhibit the outrageous inflation of prescription drug prices that adds to the runaway escalation of health care costs. Moreover, we caution that, in the absence of strict Federal regulations, the consequences of cost-saving measures without flexibility to address unique medical needs could have serious human consequences.

In general, the free market does not work in the health care sector. Instead of lowering costs through competition, prices are actually raised in many instances. This is especially true when brand name drugs lose their patents because brand name prices tend to go up instead of down. Sometimes, the arrival of a "me-too" drug in the marketplace can actually result in raising the price of the innovator drug (e.g., Tagamet and Zantac). Competition in the pharmaceutical arena simply does not respond to the usual laws of the free market system.

The only places we see competition actually drive prescription drug costs down are in the areas of generic drugs and formularies.

Prices can actually fall to a minute percentage of brand name costs 2 or 3 years after a generic drug comes on the market. Indeed, most generic drug manufacturers are operating on such narrow profit margins today that we worry about their survival. The government needs to encourage the generic drug sector, not handicap it, because this is the only way we consumers have to reduce our prescription drug costs. Therefore, Medicaid formularies should have the widest range of drugs available within a therapeutic category when price is not a factor (e.g., when generics are available).

Those sectors of the health care system that have implemented restrictive formularies for brand name drugs have found that real competitive market forces become effective. For example, most hospitals have drug formularies, and they can get lower wholesale prices than large chain drugstores that buy much larger quantities of a drug. Why? Because the chain drug stores have to purchase all drugs, but hospitals with formularies purchase a limited range of drugs from a therapeutic category, and no pharmaceutical manufacturer wants his drugs omitted from the formulary. Therefore, drug manufacturers are willing to sell their drugs to hospitals at very low prices.

The problem is that formularies are created for, among other things, bargaining power over the most commonly used drugs; anti-arthritics, antihypertensives, etc. However, you may think we have hospitals full of horses, but every doctor knows that when you look under the sheets you are certain to find zebras in some of the beds. Not every patient can tolerate or respond to the limited number of drugs in a restrictive formulary.

Who are the zebras? People with rare diseases who need orphan drugs that are not ordinarily listed in a formulary, people who have had an allergic reaction to a formulary drug and need a "me-too" drug that is slightly different, and people who don't respond to a standard drug, or cannot tolerate its side effects.

Does this mean that Medicaid shouldn't have a formulary? To the contrary, we believe that the great majority of people with common health conditions will respond very well to drugs in a formulary, and a great deal of money could be saved. But we caution that it must be flexible to respond to unique patients' needs, and exceptions to the rule should be easy for physicians to obtain with a mandatory immediate response required of the payor agency.

We also believe:

1. There should be a Federal formulary. If each State is permitted to develop its own formulary, the number of listed drugs will rise and fall in concert with local budget crises, and patients will suffer immeasurably. People should not have to move to another State in order to get appropriate prescriptions.

2. Non-formulary items prescribed for medical indications should be immediately available on an emergency basis for a limited period (perhaps a few weeks) until the review is complete.

3. No single source drug should be denied to a patient on the basis of expense if there is no alternative therapy for a serious or life-threatening disease. Patients should not be punished for a manufacturer's pricing strategy. The government must find another way to tackle these outrageous prices.

4. Usage for off-label indications is of critical concern to us. There are more than 5,000 rare diseases, but only 87 orphan drugs have been approved for marketing by the FDA. Obviously, until more treatment options become available, the vast majority of rare disorders are treated with drugs that are labeled for more prevalent diseases. The use of these drugs is generally bagged on peer reviewed medical literature, and if a disease is very rare, it may not even appear in the three compendia listed in the Medicare Catastrophic legislation.

For example, my children have Tourette Syndrome, a neurological movement disorder. They are treated quite successfully with a high blood pressure drug, clonidine (Catapres). However, the labeling on the drug is exclusively for hypertension. Since it is an old off-patent generic drug, no pharmaceutical company is willing to invest in getting clonidine approved for Tourette Syndrome. So unless you require State Medicaid systems to pay for drugs prescribed for off-label uses, people like my children might not be eligible to receive this very effective therapy.

We ask you to be extra sensitive to this problem because drug companies simply don't bother to get their drugs relabeled for additional indications unless they see financial advantage in doing so. If a market is small (e.g., an orphan disease) there is no financial incentive to submit a supplemental NDA to the FDA for the orphan indication.

We suggest that you codify in Medicaid law that off-label use should be governed by the three compendia rule (as in Medicare) or peer reviewed medical literature. It is also crucial that the response from the State or other review board must be rapid, and an appeal mechanism must be available if the physicians request is denied.

5. In recent years some State Medicaid agencies have passed cruel and heartless rules that have caused unnecessary and inhumane suffering. For example, several States have restricted the number of prescriptions a Medicaid patient is permitted to get each month, and nursing home patients in particular have suffered immeasurably as a result. Many of these patients may need 5 or 10 prescriptions due to a combination of chronic illnesses, but the State of Texas, for example, limits Medicaid patients to three prescriptions per month. While it is possible for doctors to ask

for exceptions, it often causes unnecessary and painful delays in treatment. Limits on monthly prescriptions should be prohibited.

6. Formularies must include medical tools for inborn errors of metabolism (such as PKU) and certain nutritional products for seriously ill people (e.g., liquid food for people who have difficulty swallowing). Controlled substances must also be available (e.g., morphine for intractable pain, amphetamines for narcolepsy, etc.) No class of drugs should be omitted because States suspect they are being abused. The fact is, there are some people who need these drugs and their doctors should not have to jump through hoops to be able to prescribe them.

Mr. Chairman, there are many problems associated with Medicaid, but we feel the major problem has been an absence of Federal policy and regulation. There are some things you should allow States to determine, but there are some policies the Federal Government must write in stone to assure that every State complies. It is not unusual, for example, for a Medicaid recipient in one State to be denied a treatment that another Medicaid patient with the same diagnosis is able to get a few miles away in a neighboring State.

We also caution that left to their own devices, some States will devise cost-saving measures that are harmful to patients in the absence of Federal controls. One State, for example, refused to reimburse a Medicaid recipient for the orphan drug Carnitor, even though the baby was dying of carnitine deficiency. They actually told the family to buy carnitine over-the-counter in a health food store without any realization that there is a difference between a prescription drug and an unregulated health food. Patients should not have to go to court to get a treatment their doctor has prescribed based on accepted medical practice.

Will formularies save money? If the experience of hospital formulary bargaining power teaches us anything, there will be money saved. For the great majority of patients with common ailments, formularies will not make a difference. Our primary concern is that in the zeal to reduce pharmaceutical costs, some States may forget the zebras, and they may introduce complicated red tape causing life-threatening delays in appropriate treatment. It is easy to discourage doctors from asking for a waiver or exception for patients who don't fit the pattern of common health conditions.

We urge you to remember the human factor as you write this law, and close the loopholes so that States must recognize the sanctity of human life. The Medicaid population is underprivileged and indigent; that is why they qualify for Medicaid. It seems to us that some State Medicaid systems have forgotten the human factor and the Federal Government has looked the other way as some very needy patients have fallen through the cracks. Formularies should be designed to improve the system, not make it worse.

We feel very strongly, Mr. Chairman, that drug pricing is only one piece of our Nation's health care puzzle, and it is incumbent upon you, the Congress, to fix the whole picture. President Clinton has made it clear that he wants to use the free market system to reconstruct health care delivery, but we don't see competition in the health care system lowering prices except for generic drugs and via formularies. NORD believes that this is a good place to start, if you remain sensitive to the differences between horses and zebras.

Mr. WAXMAN. Thank you very much, Ms. Meyers.

Mr. Allnutt.

STATEMENT OF ROBERT F. ALLNUTT

Mr. ALLNUTT. Thank you, Mr. Chairman. I will be very brief. I suspect we may be back here in a few weeks talking about a national formulary for the whole reformed health care system. And at that time, since we will be talking about limiting drugs for everyone, you will probably have the cameras here. When you talk about it just for the poor, you can't get them.

So with that thought in mind, let me make it clear, we don't object to formularies. Hospitals have them, staff-modeled HMO's have them. Increasingly other providers have them. Our industry has learned to work with those formularies. What we object is to a national formulary for Medicaid or for any other system.

The Bush administration, I know you remember, proposed one for Medicaid, and that was not successful. There was a great outcry against it. State-wide formularies, with all respect to Abbey Meyers, are not flexible, fast on their feet, compassionate. They are cost-saving devices. They are used to discourage prescribing. They are used to discourage prescribing particularly of new drugs.

I know you know the situation in California well when there was a formulary there. Only 1 out of 3 of the 100 most prescribed drugs in the United States was not available to the medical patients under the medical formulary. And new drugs did not get on the formulary because they were more expensive. They may be more effective and have fewer side effects, but they were not on the California formulary.

That kind of formulary can be a death sentence for a product, national formulary or a State formulary. If it doesn't make it on that list it can be sentenced to death. That is our interest, an economic interest in not having such a formulary, and it can be extremely detrimental to patients. States are realizing this pre OBRA 90. We started to see States that had State-wide formularies repealing them. Half a dozen States had done that immediately prior to OBRA 90. OBRA 90 tried to strike a balance between the access and the rebates that are paid. We are paying the rebates and we believe that balance ought to be continued.

In my statement I make a further point that simply not allowing the States to go back to formularies would not really be enough in terms of access to Medicaid patients. You need to look at prior authorization and the way it is being misused around the country now. States have simply—in California it is simply a clone of the formulary system that was there before. It is now called prior authorization and it works the same way, and it is not good for us or the patients.

I would urge you to take a look at prior authorization. And I would like to submit for the record a statement made by Senator Pryor immediately after the OBRA 90 Act was passed commenting on the second statement that I would like to give you for the record, which was a letter written by Secretary Sullivan, both of them saying prior authorization should be used only in rare cases, not across the board under the law. And we agree with those statements and would like to put them in your record if we could, thank you.

Mr. WAXMAN. Thank you very much. We will be pleased to receive those documents for the record.

[Testimony resumes on p. 481.]

[The prepared statement and attachments of Mr. Allnutt follow:]

Statement

Pharmaceutical
Manufacturers
Association

ROBERT F. ALLNUTT
EXECUTIVE VICE PRESIDENT
PHARMACEUTICAL MANUFACTURERS ASSOCIATION

BEFORE THE

SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT
COMMITTEE ON ENERGY AND COMMERCE
UNITED STATES HOUSE OF REPRESENTATIVES

APRIL 1, 1993

Mr. Chairman and Members of the Subcommittee:

I am Bob Allnutt, Executive Vice President of the Pharmaceutical Manufacturers Association. PMA represents more than 100 research-based pharmaceutical companies, including over 30 leading biotechnology firms. Together they discover, develop and produce most of the prescription drugs used in the United States, and a substantial portion of the medicines used throughout the world. I appreciate the opportunity to testify on the Administration's proposal to repeal the prohibition against restrictive formularies contained in the Omnibus Budget Reconciliation Act of 1990 (P.L. 101-508) ("OBRA '90") and thus to allow states to establish such formularies for their Medicaid programs.

We recognize the budgetary problems that increasing Medicaid costs are causing the Federal and State governments. Medicaid prescription-drug costs, though growing, are not increasing as a percentage of overall Medicaid budgets, and are not the cause of these budget problems. Limiting patient access to medicines is not the way to attack these problems. Indeed, statewide restrictive formularies are a classic case of penny-wise, pound-foolish cost cutting. And applied to Medicaid, state formularies discriminate against our poorest citizens.

Patients react in different ways to different drugs. Appropriate therapy for one patient may not help another -- and may even be harmful. By limiting the medicines reimbursed by Medicaid, restrictive formularies can deny patients the most appropriate therapy that their physicians would prescribe for their particular conditions. Beyond the obvious health consequences, such a policy can lead to increased treatment costs for the Medicaid program as a whole.

Medicaid patients should have unrestricted access to drugs (1) approved by the Food and Drug Administration as safe and effective and (2) prescribed by their physicians. The Administration proposal would reverse the clear and laudable intent of Congress in OBRA '90 to expand the access of Medicaid patients to all of the life-saving, cost-effective medicines on the market. Although it could cut back on prescription-drug expenses, it would result in an increase in other treatment costs. Rather than helping those most in need of assistance, this change in the law would be a giant step backwards for our poorest and most vulnerable citizens.

Let me say a brief word about how Medicaid formularies worked when they were authorized in the 1980's. Nearly half the states adopted them. Seeing what problems they caused for patients and that they were not effective, a half dozen states repealed them prior to OBRA '90.

California had one of the worst restrictive formulary programs. About one-third of the top 100 prescribed drugs nation-wide was ruled off the California list -- the newer the therapy, the less likely it was to be on the approved list. Patients who needed the disfavored medicines often waited weeks for a state employee to approve them.

Case histories of what this can mean in real life included a young woman named Escobar of Los Angeles who lingered on welfare, unable to work because of repeated bouts with a painful skin condition that was well treated by a non-formulary drug. But her supply was frequently interrupted by the California system.

Throughout the 1980's, a broad-based coalition of patient, physician and minority groups worked to repeal California's restrictive drug program. Then OBRA '90 offered hope for improving the California system. But the "Medi-Cal" formulary has been perpetuated by a near-clone called "prior authorization."

Mr. Chairman, we urge your Subcommittee to reject this formulary proposal. But blocking Medicaid formularies will not be enough. "Prior-authorization" systems, authorized by OBRA '90, but intended by Congress to be used selectively, have been abused by several states -- including California -- and transformed into de facto formularies. Drug Use Review (DUR) systems, also required by OBRA '90, are being established by the states. These systems enable the states to accomplish what prior authorization was intended to achieve -- limiting fraud, abuse and improper prescribing -- without restricting access to drugs. Accordingly, we believe that Medicaid prior-authorization programs are unnecessary and should be abolished.

Formularies in Medicaid

The Medicaid program -- a joint Federal-State program for medical assistance for poor people -- provides healthcare to about 30 million persons at a cost, in Fiscal Year 1992, of $118 billion. The Medicaid program now represents the second largest budget item in state budgets. The costs of other components of Medicaid have increased sharply in recent years, but prescription-drug expenditures as a percentage of total program costs currently represent only about 6 percent of all Medicaid expenditures. In 1991, combined Federal/State Medicaid prescription-drug expenditures were $6.2 billion.

In enacting OBRA '90, Congress constructed a balanced program that expanded the access of Medicaid patients to pharmaceuticals by abolishing statewide formularies in exchange for the payment of rebates by pharmaceutical companies. According to the Congressional Budget Office, these rebates will total $1 1/2 billion this year and $6 1/2 billion in the first five years -- more than double the estimates made by the CBO at the time the law was enacted.

In a letter sent to all State Governors on February 15, 1991, then-Secretary of Health and Human Services Louis W. Sullivan wrote:

"In passing this legislation, it was the clear intention of Congress, I believe, to improve access to prescription drugs by Medicaid beneficiaries. In approving this legislation, it was likewise our belief that provisions for lower costs should be associated with improved access to prescription drugs....I am concerned by reports and speculation that the drug rebate legislation might be implemented in a way that could inappropriately restrict access to prescription drugs. In particular, it is speculated that 'prior authorization' of drug dispensing, while permitted by the statute, might be misused unfairly to deny access to medically necessary drugs for Medicaid beneficiaries. I do not believe it was the Congress's intent that this should happen."

On February 19, 1991, Senator David Pryor, one of the principal sponsors of the Medicaid provisions of OBRA '90, supported Secretary Sullivan's statement. His press release stated:

"Pryor said that he was also pleased with the letter that HHS Secretary Dr. Louis Sullivan sent to the nation's Governors indicating that the Department would be monitoring how states implement the provisions in the law which expand Medicaid patients' access to prescription drugs. 'Secretary Sullivan's letter is totally consistent with Congressional intent in this regard,' Pryor said."

The effect of state Medicaid formularies on access to new medicines is particularly important, Mr. Chairman. It can take a very long time for a restrictive formulary to cover a new drug. In the past, it took an average of four years before some states -- such as California and Kentucky -- covered new drugs on their Medicaid formularies. Simply because of such delays Medicaid patients could be denied "breakthrough" drugs that could save or prolong their lives.

In fact, OBRA '90, in prohibiting restrictive formularies for Medicaid, reflected what a number of states had been doing on their own in the preceding few years -- abolishing their restrictive formularies. The states that took such action prior to OBRA '90 include Michigan, South Carolina, Louisiana, Oklahoma, Utah and Oregon.

At the time OBRA '90 was under consideration, the Bush Administration recommended a plan that would have established a national restrictive formulary for Medicaid. Many leading organizations representing physicians and nurses as well as patient and minority groups joined in opposing that proposal and it was dropped.

That opposition is applicable to the current proposal to repeal the prohibition against restrictive formularies. Allowing states to establish restrictive formularies would mean that unlike other patients, Medicaid patients would not have access to all medicines approved by FDA. They would have access only to some of these medicines -- and not necessarily the therapies their physicians would choose to prescribe for them.

A number of studies have shown that formularies do not produce savings for the Medicaid program as a whole.

In the most recent study, in 1991, William J. Moore, Ph.D.

and Robert J. Newman, Ph.D., Department of Economics, Louisiana State University, concluded that a restrictive Medicaid formulary does not achieve significant cost savings for a state. Based on their study of 47 states, Moore and Newman concluded that restrictive Medicaid formularies may decrease drug expenditures, but that this decrease is offset by increases in other services.

"Prior Authorization" in Medicaid

Although OBRA '90 prohibited restrictive formularies for Medicaid, the law allowed states to establish prior-authorization procedures. Under that system, all new drugs must be available to Medicaid patients for six months after they are approved, but thereafter a state can require physicians to obtain approval from a state official for a drug before Medicaid will pay for that product. The intent of the law was that prior authorization would be used very selectively to control fraud, abuse, misprescribing, extraordinary costs and over-utilization.

Unfortunately, a number of states have in fact subjected a wide range of drugs to the prior-authorization provisions of OBRA '90 and established de facto restrictive formularies. Others are considering doing so, as shown by the Survey of State Medicaid Prior-Authorization Requirements attached as Exhibit A to this statement.

As required by OBRA '90, most states have implemented comprehensive Drug Use Review (DUR) systems for their Medicaid programs. In 1991, the American Medical Association, the American Pharmaceutical Association and PMA jointly developed and adopted "Principles of Drug Use Review." The "Principles" have been used by the Health Care Financing Administration, state Medicaid officials, state medical societies, state pharmacy associations and others to ensure that the prescribing, dispensing and use of pharmaceuticals are done in a medically appropriate and economically effective manner. Because DUR systems accomplish the legitimate objectives of prior authorization without restricting patients' access to medicines, we believe the prior-authorization provisions of OBRA '90 should be repealed.

In conclusion, PMA strongly opposes the Administration's proposal to repeal the prohibition in OBRA '90 against state Medicaid formularies. Repeal would discriminate against our country's poorest and most vulnerable citizens by limiting their access to needed medicines and impairing their quality of care -- and it would not help to reduce total Medicaid expenditures. Instead, Congress should repeal the prior-authorization provisions in OBRA '90 and rely on DUR systems to ensure appropriate medical and economic results.

Mr. Chairman, that concludes my prepared statement. I would be pleased to respond to any questions that you or other Members of the Subcommittee may have.

EXHIBIT A

March 1993

SURVEY OF STATE MEDICAID PRESCRIPTION DRUG PRIOR-AUTHORIZATION RESTRICTIONS

STATES	DRUGS ON PRIOR AUTHORIZATION	1993 ACTIVITY
AL	Some anti-ulcer therapy, Retin-A, Depo-Provera, nutritionals, growth hormones, all anabolic steroids, Persantine, Epogen, Clozaril, Ritalin, Lupron Depot, Synarel, Hismanal, Seldane.	Medicaid budget problems have necessitated an across-the-board budget cut of 15 percent for all providers effective April 1, 1993, through September 30, 1993.
AK	Clozaril, Lupron Depot, growth hormones, nutritionals.	
AR	Some NSAIDS, some anti-ulcer therapy, some benzodiazepine therapy, Anafranil, BuSpar, transdermal Catapres, Clozaril, Cytotec, Hismanal, nitro patches, Persantine, Prilosec, Prozac, Seldane, Tavist, Retrovir, Lactulose.	The new governor is aggressively pursuing the expansion of prior authorization for Medicaid prescription drugs. He is considering reinstating the prior-authorization contract with the School of Pharmacy or another vendor.
CA	California operates probably the most restricted Medicaid prescription drug program in the nation. Many of the most commonly prescribed drugs in most therapeutic categories are available only through prior authorization. Decisions on prior-authorization drugs are subject to terms of company contracts with Department.	The Department of Health Services is in the process of reviewing drugs by therapeutic category covered under the Medi-Cal program. The Department has completed the therapeutic class review for the anti-ulcer agents. Medi-Cal announced they intend to retain the following products on the list of contract drugs for this class: Cimetidine (Tagamet), Famotidine (Pepcid), Sucralfate (Carafate), Misoprostal (Cytotec), Omeprazole (Prilosec). Medi-Cal stated that this decision is not expected to take effect until July, 1993. As of this date, providers nor beneficiaries have been given final notification. Other therapeutic classes will be reviewed in the near future. The Governor's 1993 budget plan proposes cuts in the nine optional Medi-Cal services. The proposal assumes additional federal funding in certain areas. If this additional funding is not met, several other service cuts will be proposed, including elimination of drug coverage for certain recipients.

STATES	DRUGS ON PRIOR AUTHORIZATION	1993 ACTIVITY
CO	Some anti-ulcer therapy, Clozaril, barbiturates, benzodiazepines.	Last month the Joint Budget Committee (JBC) voted unanimously to eliminate the entire Medicaid drug program. This action was taken, in part, as a result of the passage this past November of "Amendment 1," a state-wide tax limitation initiative. Subsequently, the JBC decided not to eliminate the drug program and no cuts are expected in the program this year.
CT	Amphetamines	
DE	None	
DC	None	
FL	Pursuant to a mandate in last year's budget bill, Florida is developing its prior-authorization program. Drug categories under consideration include transdermal patches, antihistamines, anti-anxiety agents, and NSAIDS. Clozaril is already on prior authorization.	The Department of Health and Rehabilitative Services (DHRS) intends to prior authorize the listed drug categories by emergency rule in March. Along with the list, PMA member companies were sent letters inviting them to offer supplemental rebates to Florida, over and above those that were established by OBRA '90. Those companies entering into such rebate agreements will be exempt from prior authorization for products that are included in the listed categories.
GA	Anabolic steroids, growth hormones, antibiotics, some anti-ulcer therapy, NSAIDS, AIDS drugs, Clozaril, Epogen, Immune Globin, Buprenex, Prolastin, Retin-A, Lactulose, Amphetamines, Amiodarone, Phenytoin inj., Estrogen inj., Fansidor, Fluphenazine Deconoate inj., Amphotericin inj., Rowasa, Glucagon inj., Halperidol inj., Iron Dextran inj., Lanoxin, Lupron, Marinol, Moxam, Tegison.	
HI	Clozaril, appetite suppressants.	
ID	Amphetamines, acne drugs.	
IL	Drugs in a number of categories.	
IN	None	

STATES	DRUGS ON PRIOR AUTHORIZATION	1993 ACTIVITY
IA	Pursuant to a prior-authorization mandate in last year's budget bill, Iowa has subjected the following drugs to prior authorization; H2 antagonists, benzodiazepines, NSAIDS, and human growth hormone.	
KS	Drugs in a number of categories.	
KY	Some anti-infectives, most H2 antagonists, lipid-lowering agents, many other individual products.	
LA	None	
ME	None	The Department of Human Services and some within the Legislature are looking to make some "structural" changes in the drug program. Prior authorization has been mentioned as a possibility.
MD	Any prescriptions costing more than $400 per year.	
MA	Some anti-ulcer therapy, minor tranquilizers, Persantine, amphetamines, some antacids.	
MI	Benzodiazepines, Ritalin, acne drugs, and Basal Gel.	
MN	Alferon, antihemophilic factor, Hismanal, Seldane, Alglucerase, Clozaril, Declomycin, Epogen, Procrit, Neupogen, Actimmune, Lactulose, Carnitor, Prilosec, Zofran, Leukine and Prokine, Thorazine, Retin-A, Vancomycin.	
MS	Pursuant to legislation passed last session, the Division of Medicaid is enforcing prior authorization for H2 antagonists. A computer program problem has delayed indefinitely implementation of prior authorization for NSAIDS.	
MO	Amphetamines, barbiturates, acne drugs.	
MT	None	
NE	Dexedrine, growth hormones, Epogen, Nebupent.	

STATES	DRUGS ON PRIOR AUTHORIZATION	1993 ACTIVITY
NV	Amphetamines, growth hormones, Dipyridamole, Epogen, estrogen patches, Ethatab, Interferon, Ritalin, Nicorette, nutritionals, Pavabid, Cylert, Quinamm, nitro patches, Lupron.	
NH	Clozaril	
NJ	Methadone	
NM	Amphetamines, minor tranquilizers.	
NY	None	
NC	None	
ND	None	
OH	Drugs in a number of categories.	
OK	None	Bills that would repeal the state's prohibition against prior authorization are moving through the legislature.
OR	Minor tranquilizers, amphetamines, acne drugs, Persantine, Yohimbine, Rogaine, legend laxatives, growth hormones, food supplements, some anti-ulcer therapy.	
PA	None	
RI	Drugs in a number of categories.	
SC	Amphetamines, Lactulose, Calcitrol, Persantine, acne drugs, nutritionals, immunosuppressants.	
SD	Clozaril	
TN	Anti-depressants, NSAIDS, growth hormones, Clozaril, Lactulose, Prilosec.	A possible reduction in revenues from the Medicaid hospital tax could lead to major cuts in Medicaid, including elimination of all optional programs. Such a scenario could jeopardize the drug program.

STATES	DRUGS ON PRIOR AUTHORIZATION	1993 ACTIVITY
TX	Growth hormones, some anti-ulcer therapy.	A proposal to eliminate the Medicaid drug program was advanced in this year's session by the state's Legislative Budget Board. However, the proposal was not adopted by the legislative budget committees, and the drug program was protected from cuts.
UT	Clozaril, anorexants, growth hormones.	
VT	Therapeutic vitamins, cathartics, antacids, analgesics, fecal softeners, Nicorette gum.	
VA	Pursuant to a mandate in last year's budget bill, the Department is developing its prior-authorization program. Drugs and categories that are under consideration include: Retin-A, growth hormone, amphetamines, nicotine patches, high-cost antihistamines, H2 antagonists, Prilosec, NSAIDS, Xanax, and BuSpar.	Legislation that establishes a Medicaid Prior Authorization Advisory Committee, requires written notice to all manufacturers whose products are to be considered for prior authorization and requires a fiscal impact study of the potential additional pharmacy, physician, outpatient and hospitalization costs that would be generated by placing a drug on prior authorization passed the legislature this session.
WA	Drugs in a number of categories.	
WV	None	Budget constraints have led the Legislature to propose major cuts in all segments of the Medicaid budget, including the drug program. Under the legislation being considered, provider taxes would be assessed on all providers, and prior authorization would be considered for the drug program. The Legislature is looking to cut some $20 million from the drug program.
WI	Schedule III and IV stimulants with the exception of Mazindol, Orthoclone OKT3, growth hormones, Lactulose, nutritionals, Clozapine, Epoetin Alfa, TPN, and Interferon.	Budget constraints led the Governor to propose expansion of prior authorization to unspecified product areas.
WY	None	A proposed budget amendment to eliminate the Medicaid drug program for adults was defeated this session.

UNITED STATES SENATE • SPECIAL COMMITTEE ON AGING

NEWS RELEASE

SENATOR DAVID PRYOR, CHAIRMAN

February 19, 1991
FOR IMMEDIATE RELEASE

Contact: Kris Phillips
202/224-5364

CHAIRMAN PLEASED WITH HCFA PLAN TO IMPLEMENT MEDICAID DRUG BILL

WASHINGTON -- Chairman David Pryor (D-Ark) said today that he was satisfied with the final Medicaid drug rebate program agreement released to the manufacturers Friday by the Health Care Financing Administration (HCFA).

This agreement will implement a part of the the Medicaid drug rebate program enacted last year, which was initiated by Pryor.

"In my mind, the rebate agreement represents a well-developed, well-balanced document that fairly considered the concerns of all parties involved" Pryor said. "HCFA has done an very good job of laying the groundwork in a short time frame for a complex, but very important program."

Pryor said that he was also pleased with the letter that HHS Secretary Dr. Louis Sullivan sent to the nation's Governors indicating that the Department would be monitoring how states implement the provisions in the law which expand Medicaid patients' access to prescription drugs. "Secretary Sullivan's letter is totally consistent with Congressional intent in this regard," Pryor said. "Congress has asked the Department, along with the General Accounting Office, to assess the impact of the now-improved prior authorization mechanisms on Medicaid patients' access to needed prescription medications. I look forward to the findings on this important topic."

Pryor did say that he was surprised that the Department defined a "nominal price" as any price that is less than 10% of the Average Manufacturer's Price (AMP). Under the law, "nominal prices" are excluded from calculating manufacturer rebates. "While this percentage seems a bit high," Pryor said, "it seems that drug manufacturers have very little excuse to eliminate the very low drug prices that they offer to family planning clinics or other charitable institutions, now that HCFA has made the nominal price so high."

The Chairman continued to reiterate his serious concern about the reports still being received by the Aging Committee about manufacturer cost shifting occurring in the market.

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MEMBERS
David Pryor, Arkansas

John Glenn, Ohio
Bill Bradley, New Jersey
Quentin N. Burdick, North Dakota
J. Bennett Johnston, Louisiana
John B. Breaux, Louisiana
Richard Shelby, Alabama
Harry Reid, Nevada
Bob Graham, Florida
Herbert Kohl, Wisconsin

John Heinz, Pennsylvania
William S. Cohen, Maine
Larry Pressler, South Dakota
Charles E. Grassley, Iowa
Pete Wilson, California
Pete V. Domenici, New Mexico
Alan K. Simpson, Wyoming
John Warner, Virginia
Nancy Landon Kassebaum, Kansas

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

FEB 15 1991

[SAMPLE OF LETTER TO ALL GOVERNORS]

Dear

In the most recent Omnibus Budget Reconciliation Act, Congress enacted important new provisions regarding the availability of prescription drugs through state Medicaid programs. This legislation requires drug manufacturers to give rebates to Medicaid programs, as is appropriate for a large purchaser and necessary for states in a time of continuing increases in Medicaid costs; and, at the same time, provides for improved access to drugs under a state Medicaid prescription program.

In passing this legislation, it was the clear intention of Congress, I believe, to improve access to prescription drugs by Medicaid beneficiaries. In approving this legislation, it was likewise our belief that provisions for lower costs should be associated with improved access to prescription drugs. State savings from lower prescription drug costs could also be used for other improvements in health care access for our needier citizens.

No one knows better than I the pressures that result from rapidly increasing health care costs. These pressures affect federal, state and local programs alike, and indeed affect our personal budgets as well. In Medicaid, they have an impact simultaneously on state and federal spending, as a result of the federal reimbursement provided to state Medicaid programs. For that reason I welcome, as I know you do, the provisions by Congress enabling your Medicaid program to get rebates for prescription drugs.

At the same time, however, I am concerned by reports and speculation that the drug rebate legislation might be implemented in a way that could inappropriately restrict access to prescription drugs. In particular, it is speculated that "prior authorization" of drug dispensing, while permitted by the statute, might be misused unfairly to deny access to medically necessary drugs for Medicaid beneficiaries. I do not believe it was the Congress's intent that this should happen. The Department of Health and Human Services will closely monitor this and other implementation to ensure that the intent of the law is properly carried out.

In the coming weeks, I will be signing agreements with drug companies to implement the rebate provisions. I am asking you to work hard to ensure that the lower costs your Medicaid program incurs as a result of these agreements will be associated with an appropriate improvement in access to drugs or other needed services for your beneficiaries.

I know that you share the dual goals of containing health care cost increases and improving access to care for our citizens who need it. I also am well aware of the inherent difficulty of achieving both these goals. In the new drug rebate provisions, we have one mechanism that will indeed help achieve both goals. I hope that we can work together to ensure that the intent of the legislation is carried out.

Sincerely,

Lou

Louis W. Sullivan, M.D.

Mr. WAXMAN. Ms. Fensterer.

STATEMENT OF DEE FENSTERER

Ms. FENSTERER. Thank you, we appreciate this opportunity. I have given in my testimony an example of the different brand price and generic drugs and you will see from that example over a 4-year period what traditionally happens is that the cost of the brand increases and the cost of the generic decreases.

I gave the example because I would hope that in deciding whether State Medicaid offices have the option to contain costs through restrictive formularies, we hope the committee will consider whether such a change will disrupt these kinds of competitive forces that really are effectively reducing the cost of pharmaceuticals in today's marketplace. We strongly believe that when competition works it should be nurtured.

We therefore support a national open formulary for multisource drugs, which, in addition to stimulating competition, will also ensure a wide range of therapeutic choices which are available to prescribers and to their patients.

An unrestricted formulary for multisource drugs not only increases the competition for specific drug entities, but also for all drugs within a therapeutic class. In the area of hypertension, for example, a Joint National Committee on High Blood Pressure is endorsing the utilization of equally effective first line therapies which are also available generically. The committee's recommendation is expected to increase sales of lower cost generic drugs and thereby reduce the average cost of treatment for hypertension.

Restrictive formularies, on the other hand, which limit prescribing or dispensing of generic drugs will result in less competition within therapeutic classes, price stagnation, and probably longer—higher long-term costs.

We are very concerned that individual State actions regarding formulary restrictions or any other individual State cost control measures will result in 50 different programs that are designed to address budget crises rather than the long-term solutions we need to cost-effective pharmaceutical treatments.

As an example the California Medicaid program—I'm sorry we keep using California as an example—but last year imposed on generic manufacturers a 5.5 percent rebate over and above the 10 percent rebate required by Medicaid. California has also initiated a program that reviewed drugs within therapeutic categories and delisted for Medicaid coverage selected drug entities. While this program has focused on single source products, the State has considered negotiating a special price on one drug entity within a therapeutic class, and then removing from Medicaid reimbursement all other drug entities; brand and generic.

Such a massive delisting program from coverage will have the most negative effect on the most competitively priced products and like the rebate program has the potential for driving these products right out of the marketplace. Besides existing disproportionate pressure on the lower margin and most competitive products and firms, these individual State actions make it difficult obviously to maintain successful competitive businesses in such uncertain environments. So we strongly favor some national standards including a national open multisource drug formulary that preempts ad hoc State initiatives that are disrupting the marketplace and reducing, rather than nurturing pharmaceutical price competition.

We believe that a national policy which provides a single competitive environment for pharmaceuticals will ensure predictable cost containment.

Thank you, I will be glad to respond to questions.

[The prepared statement of Ms. Fensterer follows:]

STATEMENT OF DEE FENSTERER, PRESIDENT, GENERIC PHARMACEUTICAL INDUSTRY ASSOCIATION

My name is Dee Fensterer and I am president of the Generic Pharmaceutical Industry Association, which represents the leading manufacturers of generic prescription drugs. I thank the chairman and the committee for this opportunity to present the experience and views of the generic industry.

Generic pharmaceutical companies sell their products in a fiercely competitive marketplace, which is entirely different from the market for brand-name drugs. A soon-to-be-released study shows, for example, that the 1988 wholesale price for 100 tablets of Inderal (80 mg) was $37.97, while the generic equivalent cost $4. By 1992, the price of the brand had increased 51 percent to $57.36, while the price of the generic had decreased 54 percent to $1.84.

The dynamics of these price differences illustrate that there are two pharmaceutical industries in the United States. Both make products certified by the Federal Government as safe, effective and medically equivalent to one another. But it is the competition-driven generic industry that has not only contained pharmaceutical costs, but actually rolled them back.

In deciding whether State Medicaid offices should have the option to contain costs through restrictive formularies, we hope the committee will consider whether such a change will disrupt existing marketplace forces, which are effectively reducing the prices of multisource pharmaceutical products.

We strongly believe that when competition works, as it does with generics, it should be nurtured. We therefore strongly support a national open formulary for multisource drug products, which in addition to stimulating competition, will also ensure that all therapeutic choices are available to prescribers and their patients.

Unrestricted formularies for multisource drugs not only increase competition for specific drug entities, but also for all drugs within entire therapeutic classes, thereby reducing the average cost of each therapy occasion. Analysts are forecasting, for example, that generic equivalents of Tagamet, expected in the marketplace in 1994, will exert price pressure on single-source Zantac.

In the area of hypertension, the Joint National Committee on the Detection, Evaluation and Treatment of High Blood Pressure is formally endorsing utilization of equally effective first-line therapies that are also available generically. The committee's recommendation is expected to increase sales of lower-cost generic therapies and thereby reduce the average cost of treatment for hypertension.

When restrictive formularies limit the prescribing or dispensing of generic drugs, there is less competition. Formulary exclusion of any multisource drug, even in exchange for short-term discounts or other special concessions by a manufacturer of a competing product, results in a virtual halt to competition, price stagnation and, therefore, higher long-term costs.

We are also concerned that individual State actions regarding formulary restrictions or other cost-control measures will result in 50 different programs designed to address short-term budget crises rather than long-term solutions to cost-effective pharmaceutical treatments. As an example, the California Medicaid program last year imposed on generic manufacturers a 5.5 percent rebate over and above the 10 percent rebate required under the Omnibus Budget Reconciliation Act of 1990 (OBRA 90).

California has also initiated a program that reviews drugs within therapeutic categories and "delists" from Medicaid coverage selected drug entities. While this program has focused on single source rather than multiple source products, the State has considered negotiating a special price on one drug entity within a therapeutic class and then removing from Medicaid reimbursement all other drug entities, brand or generic, even those with unique indications. Such a massive "delisting" program will have the most negative effect on the most competitively-priced products, which depend on volume sales, and has the potential for driving these products from the marketplace.

Other States have implemented or proposed other types of ad hoc disincentives to competition, including rebates in excess of OBRA percentage amounts, penalty rebates for price increases that are due solely to increases in manufacturing costs, restrictions on the number and identity of product suppliers, and State taxes on pharmaceutical providers, which would be in addition to required Medicaid rebates.

Besides exerting disproportionate pressure on the lower-margin, most competitive products and firms, these individual State actions make it extremely difficult to maintain successful competitive businesses in such an uncertain environment.

So we strongly favor some national standards, including a national open multisource drug formulary, to pre-empt individual State initiatives that disrupt effective marketplace forces and thereby reduce, rather than nurture, pharmaceutical price competition. A national policy, which provides a single competitive environment for pharmaceuticals, will ensure predictable cost containment.

I will be happy to respond to any questions you may have.

Mr. WAXMAN. Dr. Butcher.

STATEMENT OF RICHARD O. BUTCHER

Mr. BUTCHER. Thank you, Mr. Chairman, Congressman Towns, Congressman Moorhead. I am Richard Butcher, President of the National Medical Association, the largest and oldest African-American health professional organization in the United States, representing 16,000 members, all of whom believe that the crisis we have faced as Americans has its roots in the absence of a national health policy; a health policy that promotes people over money.

Here we are, examining issues of pharmaceutical coverage and whether or not there will be adequate funds to address the medication needs of the American people, specifically those who rely on Medicaid for their access to care. Although we are aware of the budgetary considerations and restrictions, it is essential that those who rely on Medicaid receive first class treatment and medication.

Today, I want to formally announce that by the National Medical Association's invitation, several major African-American health care social service organization are coming to Washington on May 2 and 3, 1993. This historic gathering will address national health care reform from an African-American perspective. There will be those among you who will think that such a meeting is unrealistic, but I am here today to tell you that health care reform up until now has been a contest between competing interest groups.

Absent from this debate has been the patient, those persons whom we have taken oaths to serve. They have been silent from the discussion over national health care reform. The objective of our health summit is to right this wrong.

Two of our coalition partners, the National Urban League and the NAACP report over 32 million African-Americans. This summit will be representative of the African-American constituency in a way that has never, I repeat, never been present or vocal in the national health care reform debate. It is only fitting, therefore, that I invite you, the leaders in Congress who are responsible for developing our national health care agenda, to join us at our summit next month. And we will discuss health care reform from an African-American perspective and from those who have been victims, denied access and rejected treatment because we are African-American and poor.

The problem as we see it, is that the access to care and relying on emergency rooms has its roots in the belief that health care is not a right—that it can be sold on the marketplace. But to deny access to health care means that someone is going to die. National statistics continue to reveal a deteriorating health pattern among the African-American as well as the Hispanic communities; diseases such as hypertension, cardiovascular disease, asthma, diabetes, cancer, drug abuse, AIDS and others. This has led to an overall diminished life expectancy of 69 years which is 6 to 7 years fewer than the majority of the population.

One of the major obstacles to reversing this negative medical trend has universally been identified as improving access to health care to this population as well as getting the drug medication necessary. You will experience increasing cost in caring for the chronic and acute debilitating diseases, but we see mental and physical disabilities that come about that could have been prevented with the early access to preventive medical care which, as I stated earlier, includes drug care.

The most catastrophic result from this callous and financial neglect will be unnecessary suffering and death. We have new leadership in our country today. That new leadership is bold and energetic. We at the National Medical Association look forward to the continued dialogue and involvement in the development process in the reform of the national health care agenda.

Thank you for this opportunity to speak.

Mr. WAXMAN. Thank you very much for your statement.

Mr. Herman, it sounds like what Mr. Allnutt is saying is prior authorization and formularies end up being the same thing; that prior authorization becomes a way for States to deny some of the Medicaid population high priced drugs. Formularies, of course, could serve the same purpose. How do you respond to that?

Mr. HERMAN. I think that prior authorization programs and formularies can be compatible with each other. There are a large number of Medicaid agencies that have adopted the use of the Prior Authorization Program, but I would say that in large measure those programs have been used to a limited degree.

Iowa, for example, most recently implemented a program of prior authorization limited to four therapeutic classes of drugs. I think that as long as a State uses it for a limited number of drugs—Clozaril is a common example of how prior authorization is being used. I think as long as it is used on a limited basis it is not subject to abuse.

Mr. WAXMAN. Well, I wasn't arguing that it was subject to abuse. I was wondering how you reacted to the idea that you don't need formularies if you have prior authorization. And I certainly do see them being compatible. But from Mr. Allnutt's view, the compatibility makes him uncomfortable that people are going to be denied drugs that ought to be available.

Mr. HERMAN. In my testimony I suggest that a formulary ought to be an option for a State. A State ought to be given the opportunity to use a formulary in lieu of a prior authorization program. Both types of programs have some administrative costs associated with them. The prior authorization program is generally felt by providers to be burdensome and contributed to a hassle factor. I have heard from providers in our State that have said to me they would rather have us use a formulary rather than a Prior Authorization Program. So I think that it ought to be an option.

Mr. WAXMAN. You testified that closed formulators can save the States money. This is an argument I understand, since I am aware that many hospitals and HMO's have been extremely successful using formularies to reduce prescription drug costs. They do it selecting therapeutically equivalent drugs on the basis of price and by using this power to select as bargaining leverage in price negotiations with the drug companies. But I have a concern about State formularies and it is this: If we allow unrestricted use of State formularies I am concerned about that point Ms. Meyers made, that drugs such as AZT might be excluded on the basis of price.

Do you have any recommendations on how we might address this concern?

Mr. HERMAN. Mr. Chairman, in my written remarks, I suggest that this be dealt with in legislation and that there be appropriate safeguards put in the legislation that would prevent States from denying coverage of a prescription drug on an arbitrary basis. I think that a formulary ought to allow for at least one drug from every particular therapeutic class. I think that the formulary ought to recognize advances in drug therapy. And I think in order to do that there has to be regular and continuous review of the formulary.

I suggested in my testimony a quarterly basis. Perhaps it ought to be even more frequent and the drug utilization review committees that we have established as a result of OBRA 90 or a good opportunity to do this.

Mr. WAXMAN. Mr. Allnutt, if we can devise a formulary that still makes available drugs in every therapeutic category, would you have any problems with that?

Mr. ALLNUTT. I think you would find that many physicians and patient groups would, Mr. Chairman. The fact that two drugs are in the same therapeutic category does not—while it means they are targeted for the same state of illness or disease does not mean that patients can take them interchangeably or can just be limited to a single product.

There are many products within a category that are not—may work for one patient and not another. If you have friends or relatives who have arthritis, you will frequently—which is a frequently cited class as one where all these drugs are the same, don't try to tell that to someone with arthritis. Frequently they will go through one, two, or four, sometimes half a dozen products before they find one that is both tolerable to them and helps with that disease. That is a relatively simple disease state.

You get into more complex diseases. Just to say there is one cardiovascular drug would not be a good medical system.

Mr. WAXMAN. Since you don't think there is a real world difference, as I understood your testimony, between formularies and prior authorization, and since the States already have the ability to impose prior authorization, why should you object to adding formularies?

Mr. ALLNUTT. I am trying to get you to do something about prior authorization as well. There is some real world difference presently because some States have been slower to move in that direction than others. California took about 3 days after OBRA 90 was passed to announce, well, that is OK. It isn't going to affect us at all. We will do it all with prior authorization. I happened to be in California at the time. I know it was literally 48 hours to 72 hours before they made that announcement.

Mr. WAXMAN. Well, I understand California has been so bold as to have the Governor's budget submission to the legislature assume savings from not having to pay for high priced drugs, assuming that the administration's proposal is adopted.

Mr. ALLNUTT. That is right. But they don't have to now because through the hassle factor, as it has been called by many, what happens is physicians treating a Medicaid patient realize I am not making much money on this visit anyway. I may be losing money if I have got to make a phone call and wait for someone to come. I will do something else. I will go on to some other product.

So the result is, and you will see in testimony later today, a lot of savings in the drug budget. You can show that you save money for the drug budget. The question is what does it mean to the patient and does the patient have to come back the following week where the right product might have stopped that second visit. It is that kind of thing that doesn't show up in just looking at drug budget savings.

Mr. WAXMAN. Let me ask you one last question. The administration has thrown us back into this whole problem that was so difficult for the Congress to deal with in terms of what formulation should we adopt for the discounts. But if we have to come up with savings under the Medicaid program, why don't we provide for deeper discounts rather than letting the States go back to formularies? Why don't we provide for a deeper discount?

Mr. ALLNUTT. For the rebate?

Mr. WAXMAN. Yes.

Mr. ALLNUTT. I also support the administration's jobs policies, and if I came here and talked to you about deeper discounts or rebates, I think I would be going counter to the full employment rules that we are trying to have in this country because I would be out of work. So I am not proposing that. Obviously, there is a tremendous problem funding the Medicaid program federally and through the States.

I am not denying that there is a budget problem. What I am urging you to do is not to look to further savings in the drug portion of that.

Mr. WAXMAN. I understand that you want us not to look for further savings. But if we were to look for further savings and had to choose between giving States formularies or calling for deeper discounts under the existing program or maybe a modified program—I don't want to get you in trouble with your trade association—which do you think the PMA would recommend to you?

Mr. ALLNUTT. We would suggest to you that is not the only choice. You don't have to choose between those two. As you know well the rebates are far in excess of approaching double of what was estimated when you passed OBRA 90. But because of greater utilization far beyond what was anticipated, we are up to $6.5 billion now, an additional $6.5 billion over the first 5 years, a $1.5 billion this year.

Mr. WAXMAN. You don't want rebates and formularies. Do you have some other alternatives?

Mr. ALLNUTT. We don't want additional rebates.

Mr. WAXMAN. Do you have some alternatives? I know your choice is not to do something in this area, but you don't want to recommend either one of those?

Mr. ALLNUTT. I don't want to recommend either formularies or additional rebates. In fact, I will not recommend either one of those.

Mr. WAXMAN. I think I got an answer.

Mr. Moorhead?

Mr. MOORHEAD. Thank you, Mr. Chairman. You have commented on both the questions that I wanted to ask about, but I don't totally know whether or not California had one of the most restrictive formularies for Medicaid recipients.

Can you tell us what California used to keep therapies off the formulary, keep newer drugs?

Mr. ALLNUTT. At the time there were formularies, they had a—there was a committee or commission, I forget the name of it now, but there was a group reporting to this State health department which recommended inclusion or exclusion of drugs to that list. If you weren't on the list, and 1 out of 3 of the top 100 drugs were not on that list, one-third of them were not, then in order for a Medicaid patient to receive a drug that was not on the approved list, it was a prior authorization system.

The doctor would have to call or write an appropriate office and there were regional offices within California and wait sometimes weeks for an answer, which in some cases was probably all right. In the case of someone who has an acute condition, that can be a very serious problem.

What California did and what California does now is instead of having a list of approved drugs, they simply have a list of drugs which, if you wish to prescribe, you, the physician, have to call an 800 number in the State. That result is the same.

Mr. MOORHEAD. But you can work pretty fast if you need, if the drug the doctor really feels you need doesn't take forever to get approval, does it?

Mr. ALLNUTT. Often once you get through to the State and the State considers the matter, you do get the approval. It is the delay, the uncertainty, the tendency of physicians to say, well, that is just too much trouble. I will give you something else. That is the problem that people run into.

Mr. MOORHEAD. How long would that delay normally be?

Mr. ALLNUTT. It can be a few hours or a day. It can be longer. Depends on how quickly the State responds to the—and that varies widely around the country and within California. I mentioned in my testimony that we were aware of a case that was not atypical in Los Angeles back at that time of a young woman who was unemployed and unemployable because of a condition that she had which, if they got the right medicine, she would be fine and could work, but every time the prescription came up again, they would have to apply again. Sometimes it would take a few weeks.

She would go back into her previous state and was unable to hold a job. It is that kind of thing that doesn't show up when you say how much money you are saving in the drug budget that was a savings to the drug budget. It was a loss to the rest of Medi-Cal and it was a loss to the State welfare program.

Mr. MOORHEAD. I am trying to see what the purposes are. Are these the most expensive drugs?

Mr. ALLNUTT. Typically what a State will do is exclude expensive drugs. The States vary, but typically the first thing they will look at is a drug like Clozaril, which is for schizophrenia, which allows people not to be hospitalized at great cost, but the drug itself costs several thousand dollars a year, so that will come up on the computer screen and we look at that and we don't want too many prescriptions for that. It is costing the drug budget. They typically will go to expensive drugs first.

Mr. MOORHEAD. Are they usually drugs that have an alternative?

Mr. ALLNUTT. Sometimes they are and sometimes they aren't. In Clozaril, there are other treatments for schizophrenia, but no similar treatment. But it is not always expensive drugs. They will go to a class of antiarthritics in which there are a variety of products and try to exclude all but one of them. Part of this is economic leverage. They are trying to get companies to lower their prices. That is the way it works in small settings. If you try to do it State-wide or nationwide, as is being proposed here, you get into an inflexible, slow system that simply doesn't relate to individual physician or patient. It does not meet those needs.

Mr. MOORHEAD. I heard you explain that these prior authorizations systems are being used as de facto formularies. Could you explain to me how it works, how it plays that role?

Mr. ALLNUTT. Instead of saying here is a list of the drugs—it is hard to say it with a straight face. Instead of saying here is a list of drugs that you can't get without getting authorization from the State, that would be a formulary. Instead the statement is made, here is a list of drugs which, if you wish to prescribe, you must get the permission of the State. It really ends up being the same thing.

Mr. MOORHEAD. Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you, Mr. Moorhead.

Mr. Towns.

Mr. TOWNS. Thank you, Mr. Chairman. It is commonly stated that HMO's and hospitals use restrictive formularies now with no problems. How would the same principle work for Medicaid? Anybody start off.

Mr. BUTCHER. Well, Congressman Towns, the one thing I think that the HMO and other formularies are probably a little bit more expansive than the Medicaid formularies. One thing that I have seen is that often times with the Medicaid formulary and in taking it, they really just look at the least expensive drug which is not really all the time the best for the practicing physician to use. And I think that by doing such it makes it a lot more difficult sometimes to utilize the drugs in the formulary.

Mr. TOWNS. Thank you.

I am concerned about—Mr. Allnutt?

Mr. ALLNUTT. I think the doctor just made the point very well that the difference really is in the responsiveness of the system. And as caring as State governments or the Federal Government want to be, they simply can't respond promptly and compassionately to the millions of cases a week or thousands of cases a day of people who may need something that is not in the cookbook or may need something a little different. That is the problem that we see.

Mr. TOWNS. Yes, Ms. Meyers.

Ms. MEYERS. That is the way they work in a lot of areas now and that is not the way they should work. Let's take the drug Clozaril. It is a miraculous drug for the types of schizophrenia that have not responded to other drugs. People have been institutionalized repeatedly for years. Well, the fact is a State formulary, if it is run right, would say you try all these other antipsychotic drugs that are out there, and if they don't work, then you go on to this.

And in the case of Clozaril, as a matter of fact, it is labeled to say that it should not be used on anybody who has not failed on three or four antipsychotics in the past. And so you could see moving up the ladder by starting with the less expensive and moving on to the most expensive. That is the way it should be.

Ms. FENSTERER. And the example I gave of hypertension, that is exactly the first line therapies that were selected were not selected just because they are available generically and are reasonably priced. They were also selected because they are equally effective and have been in use for a much longer term, have gone through well-controlled clinical trials and physicians have real good experience with them over time in their private practices. So this is a group of physicians who have chosen certain products to be the first line products used.

If they are not effective, obviously, you go to something else and so I am agreeing with Ms. Meyers that is exactly the way a proper formulary should work.

Mr. TOWNS. Yes, Mr. Herman?

Mr. HERMAN. I think Medicaid programs can be sensitive to the needs of the providers and to the patients. I think that prior authorization programs ought to be well-constructed. I think they can respond timely. We have a prior authorization program that uses 800 WATS lines where the physicians calls in and speaks to a pharmacist with a physician as backup and our response time is a matter of minutes. I think that there are—Clozaril is an example of a drug where response time isn't all that important. I think that is a good example of a drug that can be on prior authorization because it is one that generally the physician makes his decision, his or her decision well in advance of whether or not they are going to prescribe that drug.

Again, I think that prior authorization programs can work and are compatible with a formulary.

Mr. TOWNS. Why does it take so long to get new therapies placed on the formulary? Why does it take so long to get new drugs placed on the formulary?

Mr. Allnutt?

Mr. HERMAN. We have no experience in Iowa with a formulary, but my understanding is that in the past there have been committees that dealt with the issue of putting new drugs on the formulary and maybe they are not meeting frequently enough. That is the reason I suggest under pharmacy reform where every State has a drug utilization review committee that could be more timely.

Mr. ALLNUTT. I think it is simply a matter of a State committee or a government committee getting around to considering the issue and making a decision. The example we used to use in fighting the Medi-Cal formulary in California was the anti-ulcer medicine. The first was Tagamet. My recollection it took 55 months to get approved to be available to Medi-Cal patients. That meant 4½ years after that medicine was on the market that Medicaid patients in California were having stomach surgery when they could have been taking a drug that would prevent it.

You would think that would be something that would have been taken up quickly. It is not a life-threatening disease normally but a very serious matter, but it took 55 months. I don't know why it took so long but it did. The average in California for a new drug was 20 months. When they had a formulary it took 20 months from FDA approval until the drug was available to Medicaid patients. I don't have those statistics in mind for other States, but I happen to remember the California case.

Mr. TOWNS. Mr. Chairman, I know my time is expired. Will there be another round?

Mr. WAXMAN. Why don't you just go ahead.

Mr. TOWNS. Dr. Butcher, what do you see as the particular constraints for physicians in treating Medicaid patients if we reinstitute State drug formularies?

Mr. BUTCHER. To answer that question, I think that there needs to be an understanding of what form that is going to take place. Right now I think that certain factors are important.

First of all, that the population that we are talking about, the Medicaid population, is probably sicker than the average population. We were seeing in our offices, my practice in San Diego, I have a 60 percent Medi-Cal population so that means that we are seeing a larger number of patients. The area where I practice we have a physician-patient ratio of 1 to 2,200 where you take another section of our town called La Jolla, it is 1 to 200. We are seeing larger numbers of patients.

In doing that, if we have to go and have onerous—and I use the word "onerous" when we talk about prior authorization—to get an OK to use a drug that is different, that in my medical opinion I have examined, evaluated the patient and feel that they need, I need to get extra help in my office to help take care of it. Even calling 800 numbers I can't see the next patient. So I think that there is a personal and direct patient care effect with this when you are dealing at that level.

Mr. TOWNS. Thank you.

Let me ask, do you believe that formularies would further exacerbate a two-tier medical system as it pertains to access to the best possible drug therapy? If you do believe that is the case, I would like each of you to elaborate on why you think this administration's proposal would have this effect.

Mr. HERMAN. Mr. Towns, I do not believe that would be the case. It has already been stated that formularies have successfully been used by HMO's and other managed care entities that are more common in the private sector.

Mr. TOWNS. Ms. Meyers.

Ms. MEYERS. I don't think it would make the two-tier system worse and what I mean by that is Medicaid is a terrible system. It hasn't worked very well for the last 20 years. It has gotten worse as time goes on and as far as we are concerned it should be thrown out and people, no matter what their income is, should all be treated equally. I don't think there should be a privileged class of people in this country who can get better care than others.

I don't think that formularies are going to make it any worse than it is. If the formularies are designed correctly, as we are talking about, to make sure that they respond to patient need, that they don't make doctors jump through hoops to get a special prescription, that they are not governed totally on saving money but finding the best drug for people and that you don't give somebody a drug that is just going to help them partially if something is out there, that will help them completely.

Mr. TOWNS. Mr. Allnutt?

Mr. ALLNUTT. I have to assume that in proposing—my answer to your question is, yes. I have to assume that in proposing formularies, the OMB feeling is that will further restrict drugs. They say they will save $100 million or so over 5 years in the drug budget. CBO says, no, it is $225 million that will be saved over 5 years, so they are assuming greater restrictions on availability of drugs to Medicaid patients than exist today. So my answer to your question is, yes, that would make the system even less fair than it is now.

Ms. FENSTERER. I would like to go in answering that question back to a question from the chairman of other ways, perhaps, to save costs. In the multisource drug market now Medicaid pays two very different prices depending on whether a generic or a brand is dispensed. In testimony before the health care task force on Monday, I gave just one example and I am sorry I don't have it with me, but I believe the drug was Inderal, which is used for hypertension.

If the brand name is dispensed in Medicaid, Medicaid pays the pharmacist something like $67. That would be for 100 tablets. If the generic is dispensed, the pharmacist receives only $2.33. Pharmacy organizations have called Medicaid the only prescription drug program in the country that encourages the dispensing of the most expensive products. I think there is probably a real cost saving there if the Medicaid program would fix a single reimbursement price, allow competition of all the suppliers of truly therapeutically equivalent products, but not pay for the most expensive. Set it at a median.

If anyone, whether it is a civil servant or a Medicaid patient or a Medicare outpatient prescription drug benefit, wants a more expensive product, then that patient should be paying for it, not the taxpayer. So that would be my proposal if you are looking to find other costs in the drug benefit program for Medicaid.

Mr. TOWNS [presiding]. Dr. Butcher.

Mr. BUTCHER. Congressman Towns, I do feel that it would make a two-tiered system and what you have to understand is that by practicing in that system, what would go on is that if I see Ms. X and make a diagnosis on her and say that you need certain medicines and then look and come and call that in and because she is

Medicaid now I have to change, whereas if I treat Ms. Y and treat her and make the same diagnosis, then I call in, it means that you do have to make some compromises in your medical judgment in dealing with the patient.

Now, what you try to do is that you spend time in saying "What can I get as close to the drug as possible?" and despite what everyone is saying, all drugs are not the same. All drugs do not work on patients the same. There are some studies that are going on and that is one of the things I alluded to in my testimony that we are planning on getting some of those studies and getting that information to you.

Mr. TOWNS. Thank you very much to all of you. We really appreciate your testimony and of course your entire testimony will be included in the record. So thank you very, very much for your input.

Thank you.

Our last panel consists of representatives of governmental agencies that pay 43 percent of all Medicaid costs, the States and the counties. Any reduction in Medicare and Medicaid spending particularly of $7.8 billion over 5 years can have major implications for State and local budgets.

Mr. Carl Volpe is a Senior Policy Analyst with the Nationals Governors Association. Senator Tom Bates is from the California State Legislature in California. Marilyn Krueger is the Chair of the Health Steering Committee of the National Association of Counties.

Thank you all for your patience. Without objection, each of your statements will be included in the record. I would like to ask each of you to limit your remarks to 5 minutes.

Mr. Volpe, why don't you start first.

STATEMENT OF L. CARL VOLPE, SENIOR POLICY ANALYST, NATIONAL GOVERNORS' ASSOCIATION; TOM BATES, CALIFORNIA GENERAL ASSEMBLYMAN, ON BEHALF OF NATIONAL CONFERENCE OF STATE LEGISLATURES; AND MARILYN A. KRUEGER, ON BEHALF OF NATIONAL ASSOCIATION OF COUNTIES

Mr. VOLPE. Thank you, Mr. Chairman. I appreciate the opportunity to appear before you today on behalf of the Nation's Governors to discuss the administration's proposals for Medicaid savings. I would like to take a moment, if I can, to comment generally on the current state of Medicaid programs.

It may be obvious but it still needs to be said one more time. Medicaid costs are skyrocketing and breaking State budgets. States simply cannot sustain more than 20 percent annual growth which they have been experiencing in the last 3 years. While we can argue about the causes of these increases, one fact is certain, important services for vulnerable populations are at risk and State funds for education, welfare, and other public health programs are being diverted to cover the cost of Medicaid.

The Governors believe that Members of the Congress and administration recognize the crisis facing States today and are willing and interested in relieving the pressures that this program has generated for the last half decade.

I would like to now comment specifically on the President's proposed Medicaid savings. With one exception, the Governors are generally supportive of the President's proposals. They believe it gives States greater flexibility in program administration. It increases the probability that those who truly meet criteria for long-term care can get it and all payers are held accountable before the Federal and State Governments pay for care.

I would like briefly to comment on the administrative match proposal, the drug formulary proposal, and finally the asset transfer proposal. With regard to the administrative match, it can be justified in many ways, but the reality is nothing more than a cost shift. There was a compelling public policy reason to give States an enhanced match and we believe that public policy reason remains.

Actually, one of our affiliate organizations did a State-by-State analysis of this and nationally we are expecting about a 10 percent cost shift in administrative costs in the program as a result of this proposal. Four States will experience more than a 20 percent cost shift and 9 States will experience more than a 15 percent shift. For New York, it will be approximately a 13 percent cost shift of about $36 million annually.

Mr. Chairman, when you look at it, one thing is clear. It is no easier for States to raise revenues to pay for changes in administrative costs than it is for changes in the program costs. States will be put in the position of having to look if they can't raise revenues to find savings somewhere else in the program and that is very serious.

With regard to drug formularies, the Governors support the imposition of formularies. They believe it is an important administrative tool. They have lost a lot of tools in containing costs in the program in the last several years and they view it as important. They also believe that formularies can be imposed without sacrificing quality.

With regard to transfer of assets, the Governors do support tightening the rules on transfer of assets. However, they believe that that must be done very, very carefully so that those who truly need to belong in the program remain in the program. One of the worst things that could happen is we could start denying services to individuals who truly need it.

In conclusion, we had to support the President's proposal except for that one exception of the administrative match and we look forward to working with the committee to see if we can find some alternatives for savings.

Mr. TOWNS. Thank you, Mr. Volpe.

[Testimony resumes on p. 508.]

[The prepared statement of Mr. Volpe follows:]

STATEMENT OF L. CARL VOLPE,
SENIOR POLICY ANALYST, NATIONAL GOVERNORS' ASSOCIATION

Good morning, Mr. Chairman, members of the subcommittee. I am L. Carl Volpe, a senior policy analyst at the National Governors' Association. I appreciate the opportunity to appear before you today, on behalf of the nation's Governors, to discuss the administration's proposals for Medicaid savings.

Before I discuss the President's recommendations for Medicaid savings, I would like to take a moment to comment generally on the current state of the Medicaid program. The program remains one of significant concern to our nation's Governors. At their winter meeting this past February, they again called for relief from Medicaid's rising costs. They remain interested in greater flexibility in financing and implementing the program and seek additional financial assistance from the federal government. Simply stated, rising Medicaid costs are skyrocketing and breaking state budgets. States cannot sustain the current rate of growth.

As you are well aware, Medicaid expenditures were relatively steady from 1981 through 1988 -- somewhat less than 10 percent annual growth. Since 1989, however, growth has been radically different. In the last several years, annual program growth has exceeded 20 percent. Understanding the source of this growth is rather complex and experts have found that it is almost impossible to pinpoint a single reason. However, major factors include federal mandates imposed on the states in the last decade, increased program enrollment, tremendous growth in medical prices, and court-imposed increases in hospital and nursing home reimbursement rates. While one may argue about the relative impact of these pressures, one fact is certain: important services for vulnerable populations are at risk and state funds for education, welfare, and other public health programs are being diverted to cover the costs of Medicaid. The Governors believe that members of Congress and the administration recognize the crisis facing states and are willing and interested in relieving the pressures that this program has generated for the last half decade.

It is within this context, Mr. Chairman, and members of the subcommittee, that I appear before you today to discuss President Clinton's proposals for Medicaid savings. With one exception, the proposals can be supported by the Governors. For the most part, these proposals give states greater flexibility in the design of their programs, increase the probability that only those who truly meet the criteria for care obtain it, and assure that all payers of health care are held accountable before the federal and state governments cover the costs. While the administration is to be commended for its proposals, one important one cannot be supported by Governors. That is, the administration's proposal to reduce matching funds for all Medicaid administrative costs to 50 percent.

Reduction of Administrative Match

Mr. Chairman, this proposal can be rationalized in many ways, but this is the bottom line: it is nothing more than a cost shift to the states -- a cost shift when states are least able to afford such actions. When Congress and the administration made the decision to implement enhanced administrative matching strategies, the Governors believe that they did so to meet a compelling public policy need. In no case has that compelling need changed. I would like to take several minutes to discuss some of the components of Medicaid administration that will be affected by this proposal.

Medicaid Management Information Systems (MMIS). MMIS is a specially designed data processing system that tracks data on beneficiaries and providers and is used to process Medicaid claims. This system was established to ensure that data systems among states had sufficient uniformity and administrative sophistication to meet the growing data and financial needs of both the federal and state governments. By 1991, 49 states had MMIS in operation or under development. The need for such a system remains as great today as ever. In fact, if the nation moves to a national health care system, the Governors believe that the federal government will have an even greater need to ensure that sophisticated computer systems are available to make the necessary modifications in a timely and accurate manner.

In discussing this proposal with our membership, states have reported that they have multiyear contracts with vendors to both develop and operate their computer systems. These contracts have been negotiated with the assumption that certain federal funds would be available. Reducing federal funds now could have serious and deleterious impact on the fulfillment of those contracts.

Skilled Professional Medical Personnel. Skilled medical personnel play a key role in ensuring quality in the program. The enhanced match for this function encourages states to employ medical professionals with the highest skill levels. Both states and the federal government benefit from this policy objective, and it should be continued.

Nursing Facility Survey and Certification and Peer Review Organizations, and Fraud and Abuse Units. Nursing facility survey and certification ensures that Medicaid beneficiaries are given care in facilities that meet standards. The Omnibus Budget Reconciliation Act (OBRA) of 1987 strengthened facility requirements, federally prescribed a review process for states, and reaffirmed the federal importance of this function through an enhanced federal commitment. State responsibilities have increased substantially as a result of this statute and now is not the time to retreat from the commitment of enhanced financial support.

The Governors also believe that the enhanced match for peer review organizations (PROs) should be maintained. Utilization review, quality and medical review are the cornerstones of quality assurance. Last session, the Governors were supporting changes in Title XIX that would have facilitated the implementation of Medicaid managed care systems. These changes were met with strong federal concerns for quality under managed care. Maintaining the enhanced federal match for PROs for managed care and all other quality assurance functions is consistent with that federal public policy objective.

Finally, fraud and abuse units play a key role in ensuring the integrity of the program. These units are also instrumental in recovering funds that were claimed illegally.

Drug Use Review. OBRA '90 made significant changes to the prescription drug program in Medicaid. One of those changes was a federal mandate to establish drug utilization review programs. These programs are intended to ensure that drug use patterns are within predetermined standards. The enhanced match softened the impact of this mandate and should be retained.

Effects of Administrative Reductions on States. A state-by-state analysis of the impact of the administrative match reductions has been performed Federal Funds Information for States (FFIS), an affiliate of the National Governors' Association. (The FFIS report, issued March 8, 1993, is attached.) FFIS calculated for fiscal 1994, the cost shift to states -- expressed as a percentage of total administrative dollars -- if this proposal was enacted (see Table 3). While nationally there would be a cost shift of approximately 10 percent, states are affected differentially. Four states would experience a shift of more than 20 percent, and nine states would experience a shift of 15 percent or greater. Such shifts are unbearable and unacceptable.

If this proposal is implemented, states must either raise revenues to make up for the cost shift or they must find other parts of their program that could be reduced. Regarding revenue increases, one thing is certain. It is no easier for a state to raise revenues to make up for administrative shortfalls than it is to raise revenues to fund program expansions. The Governors hope an alternative can be found. They agree with the Committee on the Budget (Report on the Concurrent Resolution of the Budget for Fiscal Year 1994) when they said that "... the Administration's proposal to cap the administration match rate for Medicaid at 50/50 would seriously undermine the ability of states to carry out mandated activities." States are currently looking for other changes to the Medicaid program that could be made without engendering a cost shift. The Governors are interested in working with Congress and the administration to find such alternatives.

Medicaid Drug Formularies

Prescription drugs are an important part of the Medicaid program -- a program where states are committed to maintaining and improving the health of Medicaid beneficiaries through cost-efficient program administration. The Governors believe that removing the prohibition on formularies is consistent with this focus. If designed correctly, quality care to beneficiaries will not suffer and states will have one more important cost containment tool in a program that has too few tools currently. The Governors believe that states, like hospitals and health maintenance organizations, can impose formularies without sacrificing quality care.

For example, in implementing formularies, states could ensure that all clinically appropriate therapies for conditions that are medically necessary are available, and that every medically necessary therapeutic class of drugs is represented by at least one drug. Moreover, states could be required to establish procedures so that if a patient is unable to achieve the desired physician's outcome using the drug on the formulary, a non-formulary drug could be approved for use. Almost every hospital and health maintenance organization that uses formularies has such a patient safety procedure in place. There is no reason to believe that this could not work for Medicaid, and states should be given the opportunity to do so.

Transfer of Assets and Estate Recovery

The Governors support a comprehensive national long-term care policy. In its absence, the burden and the cost of care will continue to fall primarily on individuals and their families. Aside from Medicaid and a private long-term insurance market that is not perceived as viable, most individuals and families must rely on personal income and assets to pay for care. In many cases, the high cost of care ultimately forces individuals to spend their life savings and turn to Medicaid for assistance.

The Medicare Catastrophic Care Act of 1988 established some rules to protect individuals and their spouses from becoming impoverished by adjusting Medicaid eligibility rules to shelter some income and assets. However, anecdotal evidence is mounting that some non-poor elderly people are using techniques to shelter assets that would otherwise have made them ineligible for Medicaid. The prevalence of this practice is unknown; however, even if relatively few people are pursuing this technique, it is a program abuse.

The Governors support tightening the rules regarding transfer of assets so that people with the resources are held accountable to pay for their share of nursing care. These changes must be crafted carefully so that people who rightly belong in the program are neither denied coverage nor are expected to pay more than is reasonable.

As part of policy adopted by the Governors in the summer of 1992, the following areas were identified where asset transfer policy might be tightened.

- Extend the current 30-month "look-back" period for the transfer of assets at less than fair market value for the purpose of qualifying for Medicaid.

- Strengthen the current penalties for transferring assets at less than fair market value. Under current law, states can only impose a penalty equal to the lesser of 30 months of coverage or the number of months resulting from dividing the uncompensated value of the transferred resource by the statewide average room rate for a Medicaid facility.
- Review trust laws to allow access to assets that now are sheltered from consideration in Medicaid eligibility.

The President's recommendation to require states to recover assets from the estates of deceased Medicaid beneficiaries requires careful consideration. The Governors currently have no policy that would either support or oppose a federally required Medicaid estate recovery program. In considering the President's proposal, Congress might also consider a policy that retains estate recovery as a state option, but allows states that aggressively engage in estate recovery to retain a greater percentage of the funds recovered.

Medicaid Personal Care Services and Third Party Liability

Consistent with the Governors' policy of establishing options in the Medicaid program, they support the President's recommendation to correct the drafting error that establishes personal care services as a mandate in 1995.

Finally, the Governors also support actions that would identify third party payers and ensure that the appropriate insurer pays for care before Medicaid.

Conclusion

Mr. Chairman and members of the subcommittee, thank you for the opportunity to appear before you today. With one notable exception, the Governors are supportive of the President's recommendations for Medicaid savings. They and their staffs look forward to working with you and the President to develop the details of these proposals, and they are committed to finding suitable alternatives to the reductions in administrative match that can only result in cost shifts to states.

I am available to answer questions. Thank you.

Issue **Brief**

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Administrative Matching Rate Proposals in the Clinton Economic Plan

Summary

President Clinton's economic plan released on February 17, 1993, would set the matching rates for the administrative costs for medicaid, aid to families with dependent children (AFDC), and food stamps at 50 percent starting in the second half of federal fiscal year 1994. According to the plan, this change would save the federal government $200 million in 1994 and $1.8 billion between 1994 and 1997. This brief analyzes the potential impact of this proposal on state medicaid and AFDC programs.

Background

As a requirement of participating in the medicaid and AFDC programs, states must provide the administrative institutions necessary to operate the programs at the state level. The costs for developing the administrative capacity to run an efficient program is shared between the federal government and the states. In most cases, the two levels of government each pay 50 percent of administrative costs. The federal government pays a larger percentage for certain administrative activities and systems that it wishes to promote, for example, fraud and abuse control. Currently, about 30 percent of all medicaid administrative costs are matched at an enhanced rate, while only 7 percent of all AFDC administrative costs receive a matching rate of more than 50 percent.

Medicaid Administration

Each state designates one agency to operate its medicaid program. The administrative responsibilities of these agencies include determining eligibility, assessing provider qualifications, developing systems for processing claims, monitoring program efficiency and effectiveness, and detecting fraud and abuse.

The federal government and the states share the costs of administering medicaid according to matching rates that vary by function. For example, 90 percent of the costs of installing a medicaid management information system are paid by the federal government, while the costs for outstationed eligibility workers are shared evenly. For 1993, the Health Care Finance Administration estimates that administering medicaid will cost a total of $5.1 billion. The 1993 state share of this total is estimated at $2.2 billion.

Table 1 shows estimated federal spending for medicaid administration by category for 1994. The descriptions below explain the purpose and matching rate for each category.

Immigration Status Verification Systems (ISVS) - 100 percent. For medicaid applicants who are not U.S. citizens, states must verify immigration status. Medicaid pays for services for eligible non-citizens with permanent resident status. Medicaid must also cover services for illegal aliens in emergency situations.

Medicaid Management Information Systems (MMIS) Installation and Operation- 90 percent/75 percent. MMIS is a model data processing system that tracks data on beneficiaries and providers and processes medicaid claims. The Mental Health Systems Act (P.L. 96-398) required all states to install an approved MMIS by September 30, 1982, or face a reduction in federal payments for administration.

By 1991, 49 states had an MMIS in operation or under development. The installation costs are matched at 90 percent; the matching rate for system operating costs is 75 percent.

Skilled Professional Medical Personnel - 75 percent. This category applies to the compensation and training of professional medical personnel, and staff directly supporting medical personnel used in program administration.

Medical/Institutional Review and Peer Review Organizations - 75 percent. States are required to conduct ongoing internal reviews of the appropriateness of care provided by each institution. These activities are carried on by a utilization review committee at each institution, usually made up of the facility's own physicians and other professionals.

Drug Use Review - 75 percent. The Omnibus Budget and Reconciliation Act of 1990 required states to implement a drug utilization review program by January 1, 1993. These programs compare actual drug use data to a predetermined set of standards to expose any patterns of inefficiency.

Preadmission Screening Review - 75 percent. Preadmission screening review programs determine the efficacy of admitting a person to a hospital or nursing home before they are actually admitted.

All Other Administrative Costs - 50 percent. The federal share of medicaid administration covers 50 percent of all other medicaid administrative costs. These costs include those for: establishing a drug rebate system, installing and operating a non-MMIS automated data processing system, nurses aide training, and outstationed eligibility workers.

AFDC Administration

Under current law, the AFDC program provides enhanced matching rates for three categories of administrative costs. The full cost of installing a systematic alien verification of entitlement (SAVE) system, which determines applicant immigration status, is covered by federal funds. Federal funds may also be used to cover 90 percent of the costs of planning, design, development, and operation of statewide automated data processing systems. The matching rate for the establishment and implementation of fraud prevention programs is 75 percent. Table 2 shows the distribution of administrative costs among these functions.

Proposed Reduction in Administrative Matching Rates

The Administration's proposal would lower the federal matching rate for all medicaid, AFDC, and food stamp administrative costs to 50 percent starting on April 1, 1994.[1] According to documents supporting the plan, some states could receive waivers in "hardship cases". Those in favor of reducing these matching rates argue that the need for the incentives they provide has expired. For example, all state medicaid programs have automated data processing systems and fraud control programs. Reducing the matching rates would encourage administrative efficiency. Opponents of the proposal believe that it would force states to reduce administrative costs at the expense of program efficiency, higher error rates, or reduced fraud control efforts.

Tables 3 and 4 show the effects on federal payments to states for medicaid and AFDC administration if the matching rates were lowered for all of fiscal year 1994. The Clinton administration's proposal would only affect payments for the second half of the fiscal year. As a rule of thumb, the effect of the

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1/ A recent Congressional Budget Office study indicated that 4/5 of the total savings would come from medicaid, while AFDC and food stamps would account for the remaining savings. Data to calculate the impact on food stamp administration is not available at this time.

Administration's proposal would be about half of that shown in table 3 and 4. However, states might respond to the proposal by shifting more administrative costs into the first half of the fiscal year. The tables are intended to show the relative impact of the proposal on each state.

In general, states with relatively large proportions of their funds matched at more than 50 percent would experience the largest cost shifts. For medicaid, the largest reductions in federal funding would occur in Nevada (-$5.5 million, 25.2%), Alabama (-$6.0 million 21.6%), Wyoming (-$1.0 million, 21%), Alaska (-$2.4 million, 20.3%), New Hampshire (-$2.3 million, 19.7%), and Delaware (-$2.0 million, 19.7%). Of the total savings of $303 million, 32 percent would come from savings in California (-$42 million, 6.8%), New York (-$37 million, 12.7%), and Texas (-$16.5 million, 11.8%).

Reducing the AFDC administrative matching rates starting October 1, 1993, would save the federal government $52 million, a 2.9% reduction from current estimates. States most affected by a reduction in administrative matching rates for AFDC include Wyoming (-$721 thousand, 23.6%), West Virginia ($751 thousand, 14.4%), Kentucky (-$2.9 million, 11.0%), Minnesota (-$3.7 million, 10.8%), and South Carolina (-$1.2 million, 10.3%). Connecticut and New York, which currently share all of their administrative costs at 50 percent, would not be affected by the proposal. Nebraska and North Carolina would receive reductions of less than $1,000.

Outlook

Specific information on this proposal will likely be included in the Administration's *1994 Budget*, scheduled to be released on April 5, 1993. Congress will then consider the proposal as part of the 1993 Congressional budget resolution and reconciliation bill later this spring and summer. A similar proposal was rejected by Congress when the Bush administration included it in its *1990 Budget*.

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Table 1. Distribution of Federal Medicaid Administration Payments by Matching Rates, 1994

(federal fiscal years, dollars in thousands)

	100%	90%		75%					50%					
State	ISVS	MMIS	OTHER	MMIS	SPMP	PRO	DRUGU	PASR	DRUGI	ADP	OTHER	NAT	OEW	TOTAL
Alabama	$0	$452	$135	$15,064	$1,640	$0	$0	$608	$0	$448	$9,544	$0	$0	$27,891
Alaska	0	257	0	5,379	615	318	0	370	0	536	3,975	88	0	11,538
Arizona	8	0	40	0	2,807	201	0	705	0	9,436	43,725	14	0	56,936
Arkansas	14	0	0	4,181	1,165	1,275	0	1,042	0	0	13,031	1,283	317	22,308
California	5,000	324	0	83,041	34,761	0	0	0	0	5,016	495,172	0	0	623,314
Colorado	0	225	0	7,377	565	1,928	170	789	0	0	12,523	311	0	23,888
Connecticut	0	157	0	5,060	800	428	126	757	0	4,575	17,892	41	0	29,836
Delaware	0	1,030	0	2,240	1,231	143	0	980	0	0	4,490	0	0	10,114
Dist of Col	0	1,036	0	3,073	1,311	392	0	0	0	0	8,170	0	0	13,982
Florida	142	0	0	16,128	5,610	140	0	4,347	0	18,232	95,650	0	0	140,249
Georgia	0	0	0	22,740	13,073	0	0	2,975	0	1,797	45,522	2,244	0	88,351
Hawaii	0	0	0	3,135	676	0	180	0	0	0	6,622	0	0	10,613
Idaho	0	119	0	6,104	1,043	600	0	141	0	668	6,848	160	0	15,683
Illinois	4	22	0	24,783	3,846	879	0	6,114	0	0	85,132	468	0	121,248
Indiana	0	0	0	0	195	0	0	2,814	0	1,404	25,000	0	0	29,413
Iowa	2	684	0	5,610	126	2,955	0	75	0	1,370	13,662	60	15	24,559
Kansas	0	0	0	5,995	388	1,345	0	125	0	0	8,451	0	0	16,304
Kentucky	4	144	0	8,025	648	2,295	225	900	0	0	15,682	1,000	0	28,923
Louisiana	0	0	0	17,223	803	0	0	2,842	0	0	38,114	913	0	59,895
Maine	0	0	0	3,981	511	0	0	75	0	0	8,911	0	0	13,478
Maryland	38	6,154	0	8,920	6,185	3,344	0	2,079	0	0	46,965	1,938	0	75,623
Massachusetts	0	0	45	13,063	2,930	0	0	1,408	0	168	45,145	1,224	0	63,983
Michigan	0	382	0	22,002	1,833	605	194	4,648	0	727	66,152	3,661	2,400	102,604
Minnesota	0	6,495	0	4,339	3,405	640	0	164	0	4,842	49,454	0	0	69,339
Mississippi	0	261	0	9,158	656	1,575	0	863	0	1,200	9,500	588	0	23,801
Missouri	0	0	0	6,186	717	0	0	1,836	0	0	26,580	29	170	35,518
Montana	0	0	0	1,265	53	283	248	149	0	0	4,915	161	0	7,074
Nebraska	0	180	0	4,495	565	750	0	840	0	0	9,423	120	0	16,373
Nevada	0	9,818	531	0	1,324	870	0	68	0	693	7,598	313	0	21,215
New Hampshire	0	172	0	5,750	653	148	0	103	0	0	4,831	0	0	11,657
New Jersey	0	0	3,922	9,990	6,543	120	188	1,295	0	180	74,155	0	1,500	97,893
New Mexico	1	0	28	3,984	1,014	900	0	450	0	0	6,509	80	0	12,966
New York	0	360	8,910	67,099	21,675	7,500	0	879	0	0	174,500	6,210	0	287,133
North Carolina	0	0	0	6,683	1,279	495	0	229	0	1,430	49,500	55	0	59,671
North Dakota	0	0	0	821	393	120	22	153	0	0	4,868	260	0	6,637
Ohio	0	1,632	0	15,160	6,972	1,451	38	2,850	0	1,356	67,291	100	0	96,850
Oklahoma	1	0	416	6,080	4,051	411	20	1,622	31	0	35,838	0	0	48,470
Oregon	0	739	266	12,059	3,936	135	0	625	0	0	37,172	619	0	55,551
Pennsylvania	8	86	0	30,769	5,878	0	450	792	0	0	89,019	0	768	127,770
Rhode Island	5	5,266	0	0	342	0	0	140	0	3,811	6,658	15	608	16,845
South Carolina	0	450	1,595	7,233	4,056	342	0	2,001	0	0	19,684	226	868	36,455
South Dakota	0	0	0	720	270	120	64	6	0	0	3,440	86	0	4,706
Tennessee	525	0	0	8,275	2,590	1,037	119	1,558	0	0	25,539	0	1,215	40,858
Texas	115	172	248	36,756	6,784	0	0	5,230	100	10,509	76,821	842	3,028	140,605
Utah	0	918	0	6,259	1,913	0	0	0	0	0	10,075	182	0	19,347
Vermont	0	406	0	2,957	683	0	0	104	0	209	5,125	38	0	9,522
Virginia	0	86	0	8,359	1,765	0	102	2,813	42	0	13,556	668	10,001	37,392
Washington	0	277	36	9,861	4,797	0	210	0	0	0	47,073	0	184	62,438
West Virginia	0	0	0	3,492	1,851	963	0	201	0	0	10,856	68	72	17,503
Wisconsin	4	142	0	8,730	116	1,049	0	740	0	5,323	17,350	402	0	33,856
Wyoming	0	545	40	1,521	387	151	0	244	0	0	1,987	30	0	4,905
Puerto Rico	0	0	0	0	0	0	0	0	0	0	7,000	0	0	7,000
Virgin Islands	0	0	0	0	0	0	0	0	0	0	441	0	0	441
Territories	0	0	0	0	84	0	0	0	0	0	451	0	0	535
Total	$5,871	$38,991	$16,212	$561,125	$167,514	$35,908	$2,356	$59,749	$173	$73,930	$2,013,587	$24,497	$21,146	$3,021,059

Abbreviations: ISVS - Immigration Status Verification System. MMIS - Medicaid Management Information System.
SPMP -Skilled Professional Medical Personnel. PRO - Peer Review Organization. DRUGU - Drug Utilization Review. PASR - Preadmission Screening
DRUGI - Drug Implementation costs. ADP - Automated Data Processing. NAT - Nurse Aide Training. OEW - Outstationed Eligibility Workers.
Source: HCFA Form 37, December 1992.

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Table 2. Distribution of Federal AFDC Administration Payments by Matching Rates, 1994

(federal fiscal years, dollars in thousands)

	Federal Share					Percent Matched at			
	100%	90%	75%	50%					
State	SAVE	FAMIS	CFA	Other	TOTAL	100%	90%	75%	50%
Alabama	$1	$0	$525	$15,125	$15,651	0.01%	0.00%	3.35%	96.64%
Alaska	0	506	285	4,896	5,687	0.00%	8.89%	5.01%	86.09%
Arizona	20	557	0	22,246	22,823	0.09%	2.44%	0.00%	97.47%
Arkansas	2	200	500	6,231	6,932	0.03%	2.88%	7.21%	89.88%
California	15,000	0	15,000	429,350	459,350	3.27%	0.00%	3.27%	93.47%
Colorado	5	859	1,938	12,350	15,152	0.03%	5.67%	12.79%	81.51%
Connecticut	0	0	0	15,845	15,845	0.00%	0.00%	0.00%	100.00%
Delaware	0	706	96	4,138	4,940	0.00%	14.28%	1.94%	83.77%
Dist of Col	0	1,748	364	11,926	14,038	0.00%	12.45%	2.59%	84.96%
Florida	15	1,647	2,760	47,782	52,204	0.03%	3.15%	5.29%	91.53%
Georgia	1	1,085	1,471	28,298	30,854	0.00%	3.51%	4.77%	91.72%
Hawaii	1	697	0	5,828	6,526	0.02%	10.68%	0.00%	89.30%
Idaho	0	415	92	5,132	5,639	0.00%	7.36%	1.64%	91.01%
Illinois	17	1,495	0	37,666	39,178	0.04%	3.82%	0.00%	96.14%
Indiana	0	3,668	0	18,938	22,606	0.00%	16.22%	0.00%	83.78%
Iowa	1	342	0	8,371	8,714	0.01%	3.92%	0.00%	96.06%
Kansas	0	77	551	7,938	8,566	0.00%	0.89%	6.44%	92.67%
Kentucky	0	6,709	0	20,498	27,207	0.00%	24.66%	0.00%	75.34%
Louisiana	0	79	41	12,530	12,650	0.00%	0.63%	0.32%	99.05%
Maine	0	0	62	6,130	6,192	0.00%	0.00%	0.99%	99.01%
Maryland	21	1,419	627	27,342	29,409	0.07%	4.83%	2.13%	92.97%
Massachusetts	0	2,256	0	36,550	38,806	0.00%	5.81%	0.00%	94.19%
Michigan	0	6,504	0	81,237	87,741	0.00%	7.41%	0.00%	92.59%
Minnesota	0	6,165	2,730	24,966	33,861	0.00%	18.21%	8.06%	73.73%
Mississippi	0	653	0	7,662	8,315	0.00%	7.85%	0.00%	92.15%
Missouri	3	2,192	0	13,905	16,100	0.02%	13.62%	0.00%	86.36%
Montana	0	0	24	3,387	3,411	0.00%	0.00%	0.70%	99.30%
Nebraska	1	0	0	6,601	6,602	0.02%	0.00%	0.00%	99.98%
Nevada	11	1,467	279	6,863	8,620	0.13%	17.02%	3.24%	79.62%
New Hampshire	0	0	0	2,163	2,163	0.00%	0.00%	0.00%	100.00%
New Jersey	10	360	8,675	80,882	89,927	0.01%	0.40%	9.65%	89.94%
New Mexico	2	0	128	6,034	6,164	0.03%	0.00%	2.07%	97.90%
New York	0	0	0	265,524	265,524	0.00%	0.00%	0.00%	100.00%
North Carolina	1	0	0	29,627	29,628	0.00%	0.00%	0.00%	100.00%
North Dakota	1	432	0	1,832	2,265	0.04%	19.07%	0.00%	80.88%
Ohio	0	9,266	0	67,262	76,528	0.00%	12.11%	0.00%	87.89%
Oklahoma	1	827	446	20,196	21,470	0.00%	3.85%	2.08%	94.07%
Oregon	0	0	564	15,735	16,300	0.00%	0.00%	3.46%	96.54%
Pennsylvania	42	0	722	57,647	58,411	0.07%	0.00%	1.24%	98.69%
Rhode Island	290	90	0	3,032	3,412	8.50%	2.64%	0.00%	88.86%
South Carolina	0	2,724	0	9,027	11,751	0.00%	23.18%	0.00%	76.82%
South Dakota	0	142	47	1,956	2,145	0.00%	6.63%	2.17%	91.20%
Tennessee	1	3,677	221	15,612	19,511	0.01%	18.84%	1.13%	80.02%
Texas	99	477	2,004	44,794	47,373	0.21%	1.01%	4.23%	94.55%
Utah	15	891	3	5,986	6,895	0.22%	12.92%	0.04%	86.82%
Vermont	0	103	0	2,749	2,852	0.00%	3.60%	0.00%	96.40%
Virginia	0	130	8	20,786	20,923	0.00%	0.62%	0.04%	99.34%
Washington	100	0	0	36,257	36,357	0.28%	0.00%	0.00%	99.72%
West Virginia	1	1,689	0	3,511	5,201	0.02%	32.48%	0.00%	67.50%
Wisconsin	6	2,925	3,464	24,355	30,750	0.02%	9.51%	11.26%	79.20%
Wyoming	15	1,605	0	1,431	3,051	0.49%	52.60%	0.00%	46.91%
Total	$15,683	$66,781	$43,625	$1,646,129	$1,772,218	0.88%	3.77%	2.46%	92.89%

Abbreviations: SAVE - Systematic Alien Verification of Entitlement, FAMIS - Family Assistance Management Information System
CFA - Control of Fraud and Abuse

Source: Administration for Children and Families, Form FSA-231, April 1992.

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Table 3. Possible Full-Year Effects of Reducing Administrative Matching Rates for Medicaid to 50 Percent

(federal fiscal years, dollars in thousands)

	Amount Matched at				1994	Percent Matched at				Possible Cost Shift to States*	
State	100%	90%	75%	50%	Total	100%	90%	75%	50%	Dollars	Percent
Alabama	$0	$587	$17,312	$9,992	$27,891	0.00%	2.10%	62.07%	35.83%	$6,032	21.63%
Alaska	0	257	6,682	4,599	11,538	0.00%	2.23%	57.91%	39.86%	2,342	20.29%
Arizona	8	40	3,713	53,175	56,936	0.01%	0.07%	6.52%	93.39%	1,259	2.21%
Arkansas	14	0	7,663	14,631	22,308	0.06%	0.00%	34.35%	65.59%	2,561	11.48%
California	5,000	324	117,802	500,188	623,314	0.80%	0.05%	18.90%	80.25%	41,911	6.72%
Colorado	0	225	10,829	12,834	23,888	0.00%	0.94%	45.33%	53.73%	3,710	15.53%
Connecticut	0	157	7,171	22,508	29,836	0.00%	0.53%	24.03%	75.44%	2,460	8.25%
Delaware	0	1,030	4,594	4,490	10,114	0.00%	10.18%	45.42%	44.39%	1,989	19.67%
Dist of Col	0	1,036	4,776	8,170	13,982	0.00%	7.41%	34.16%	58.43%	2,052	14.68%
Florida	142	0	26,225	113,882	140,249	0.10%	0.00%	18.70%	81.20%	8,813	6.28%
Georgia	0	0	38,788	49,563	88,351	0.00%	0.00%	43.90%	56.10%	12,929	14.63%
Hawaii	0	0	3,991	6,622	10,613	0.00%	0.00%	37.60%	62.40%	1,330	12.53%
Idaho	0	119	7,888	7,676	15,683	0.00%	0.76%	50.30%	48.94%	2,682	17.10%
Illinois	4	22	35,622	85,600	121,248	0.00%	0.02%	29.38%	70.60%	11,886	9.80%
Indiana	0	0	3,009	26,404	29,413	0.00%	0.00%	10.23%	89.77%	1,003	3.41%
Iowa	2	684	8,766	15,107	24,559	0.01%	2.79%	35.69%	61.51%	3,227	13.14%
Kansas	0	0	7,853	8,451	16,304	0.00%	0.00%	48.17%	51.83%	2,618	16.06%
Kentucky	4	144	12,093	16,682	28,923	0.01%	0.50%	41.81%	57.68%	4,097	14.17%
Louisiana	0	0	20,868	39,027	59,895	0.00%	0.00%	34.84%	65.16%	6,956	11.61%
Maine	0	0	4,567	8,911	13,478	0.00%	0.00%	33.88%	66.12%	1,522	11.29%
Maryland	38	6,154	20,528	48,903	75,623	0.05%	8.14%	27.15%	64.67%	9,597	12.69%
Massachusetts	0	45	17,401	46,537	63,983	0.00%	0.07%	27.20%	72.73%	5,820	9.10%
Michigan	0	382	29,282	72,940	102,604	0.00%	0.37%	28.54%	71.09%	9,930	9.68%
Minnesota	0	6,495	8,548	54,296	69,339	0.00%	9.37%	12.33%	78.31%	5,736	8.27%
Mississippi	0	261	12,252	11,288	23,801	0.00%	1.10%	51.48%	47.43%	4,200	17.65%
Missouri	0	0	8,739	26,779	35,518	0.00%	0.00%	24.60%	75.40%	2,913	8.20%
Montana	0	0	1,998	5,076	7,074	0.00%	0.00%	28.24%	71.76%	666	9.41%
Nebraska	0	180	6,650	9,543	16,373	0.00%	1.10%	40.62%	58.28%	2,297	14.03%
Nevada	0	10,349	2,262	8,604	21,215	0.00%	48.78%	10.66%	40.56%	5,354	25.23%
New Hampshire	0	172	6,654	4,831	11,657	0.00%	1.48%	57.08%	41.44%	2,294	19.68%
New Jersey	0	3,922	18,136	75,835	97,893	0.00%	4.01%	18.53%	77.47%	7,788	7.96%
New Mexico	1	28	6,348	6,589	12,966	0.01%	0.22%	48.96%	50.82%	2,129	16.42%
New York	0	9,270	97,153	180,710	287,133	0.00%	3.23%	33.84%	62.94%	36,504	12.71%
North Carolina	0	0	8,686	50,985	59,671	0.00%	0.00%	14.56%	85.44%	2,895	4.85%
North Dakota	0	0	1,509	5,128	6,637	0.00%	0.00%	22.74%	77.26%	503	7.58%
Ohio	0	1,632	26,471	68,747	96,850	0.00%	1.69%	27.33%	70.98%	9,549	9.86%
Oklahoma	1	416	12,184	35,869	48,470	0.00%	0.86%	25.14%	74.00%	4,247	8.76%
Oregon	0	1,005	16,755	37,791	55,551	0.00%	1.81%	30.16%	68.03%	6,032	10.86%
Pennsylvania	8	86	37,889	89,787	127,770	0.01%	0.07%	29.65%	70.27%	12,672	9.92%
Rhode Island	5	5,266	482	11,092	16,845	0.03%	31.26%	2.86%	65.85%	2,504	14.86%
South Carolina	0	2,045	13,632	20,778	36,455	0.00%	5.61%	37.39%	57.00%	5,453	14.96%
South Dakota	0	0	1,180	3,526	4,706	0.00%	0.00%	25.07%	74.93%	393	8.36%
Tennessee	525	0	13,579	26,754	40,858	1.28%	0.00%	33.23%	65.48%	4,789	11.72%
Texas	115	420	48,770	91,300	140,605	0.08%	0.30%	34.69%	64.93%	16,501	11.74%
Utah	0	918	8,172	10,257	19,347	0.00%	4.74%	42.24%	53.02%	3,132	16.19%
Vermont	0	406	3,744	5,372	9,522	0.00%	4.26%	39.32%	56.42%	1,428	15.00%
Virginia	0	86	13,039	24,267	37,392	0.00%	0.23%	34.87%	64.90%	4,385	11.73%
Washington	0	313	14,868	47,257	62,438	0.00%	0.50%	23.81%	75.69%	5,095	8.16%
West Virginia	0	0	6,507	10,996	17,503	0.00%	0.00%	37.18%	62.82%	2,169	12.39%
Wisconsin	4	142	10,635	23,075	33,856	0.01%	0.42%	31.41%	68.16%	3,610	10.66%
Wyoming	0	585	2,303	2,017	4,905	0.00%	11.93%	46.95%	41.12%	1,028	20.95%
Puerto Rico	0	0	0	7,000	7,000	0.00%	0.00%	0.00%	100.00%	0	0.00%
Virgin Islands	0	0	0	441	441	0.00%	0.00%	0.00%	100.00%	0	0.00%
Territories	0	0	84	451	535	0.00%	0.00%	15.70%	84.30%	28	5.23%
Total	$5,871	$55,283	$826,652	$2,133,333	$3,021,069	0.19%	1.83%	27.36%	70.62%	$303,021	10.03%

*These estimates assume that the matching rates are lowered at the beginning of FY 1994, October 1, 1993.
The Clinton administration's proposal would not go into effect until April 1, 1994.
Source: HCFA Form 37, December 1992.

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Table 4. Possible Full-Year Effects of Reducing Administrative Matching Rates for AFDC to 50 Percent

(federal fiscal years, dollars in thousands)

State	1994 Total AFDC Administration	Possible Cost Shift to States* SAVE	FAMIS	CFA	TOTAL	Percent Reduction
Alabama	$15,651	$1	$0	$175	$176	1.12%
Alaska	5,687	0	225	95	320	5.62%
Arizona	22,823	10	248	0	258	1.13%
Arkansas	6,932	1	89	167	256	3.70%
California	459,350	7,500	0	5,000	12,500	2.72%
Colorado	15,152	3	382	646	1,030	6.80%
Connecticut	15,845	0	0	0	0	0.00%
Delaware	4,940	0	314	32	346	7.00%
Dist of Col	14,038	0	777	121	898	6.40%
Florida	52,204	8	732	920	1,660	3.18%
Georgia	30,854	1	482	490	973	3.15%
Hawaii	6,526	1	310	0	310	4.75%
Idaho	5,639	0	184	31	215	3.82%
Illinois	39,178	9	664	0	673	1.72%
Indiana	22,606	0	1,630	0	1,630	7.21%
Iowa	8,714	1	152	0	153	1.75%
Kansas	8,566	0	34	184	218	2.54%
Kentucky	27,207	0	2,982	0	2,982	10.96%
Louisiana	12,650	0	35	14	49	0.38%
Maine	6,192	0	0	21	21	0.33%
Maryland	29,409	11	631	209	850	2.89%
Massachusetts	38,806	0	1,003	0	1,003	2.58%
Michigan	87,741	0	2,891	0	2,891	3.29%
Minnesota	33,861	0	2,740	910	3,650	10.78%
Mississippi	8,315	0	290	0	290	3.49%
Missouri	16,100	2	974	0	976	6.06%
Montana	3,411	0	0	8	8	0.23%
Nebraska	6,602	1	0	0	1	0.01%
Nevada	8,620	6	652	93	751	8.71%
New Hampshire	2,163	0	0	0	0	0.00%
New Jersey	89,927	5	160	2,892	3,057	3.40%
New Mexico	6,164	1	0	43	44	0.71%
New York	265,524	0	0	0	0	0.00%
North Carolina	29,628	1	0	0	1	0.00%
North Dakota	2,265	1	192	0	193	8.50%
Ohio	76,528	0	4,118	0	4,118	5.38%
Oklahoma	21,470	0	368	149	517	2.41%
Oregon	16,300	0	0	188	188	1.15%
Pennsylvania	58,411	21	0	241	262	0.45%
Rhode Island	3,412	145	40	0	185	5.42%
South Carolina	11,751	0	1,211	0	1,211	10.30%
South Dakota	2,145	0	63	16	79	3.67%
Tennessee	19,511	1	1,634	74	1,708	8.76%
Texas	47,373	49	212	668	929	1.96%
Utah	6,895	8	396	1	405	5.87%
Vermont	2,852	0	46	0	46	1.60%
Virginia	20,923	0	58	3	60	0.29%
Washington	36,357	50	0	0	50	0.14%
West Virginia	5,201	1	751	0	751	14.44%
Wisconsin	30,750	3	1,300	1,155	2,458	7.99%
Wyoming	3,051	8	713	0	721	23.62%
Total	$1,772,218	$7,842	$29,680	$14,542	$52,063	2.94%

Abbreviations: SAVE - Systematic Alien Verification of Entitlement, FAMIS - Family Assistance Management Information System, CFA - Control of Fraud and Abuse

*These estimates assume that the matching rates are lowered at the beginning of FY 1994, October 1, 1993. The Clinton administration's proposal would not go into effect until April 1, 1994.

Source: Administration for Children and Families, Form FSA-231, April 1992.

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Mr. TOWNS. Mr. Bates?

STATEMENT OF TOM BATES

Mr. BATES. Mr. Chairman and Congressman Towns, it is a pleasure. I am sorry that Congressman Waxman was called away. I understand he will have an opportunity to review the record and I will submit formal testimony in the first place, so it is a pleasure to be here to spend a few minutes with you to talk about this from the perspective of California.

As indicated, I am a State legislator in California where I chair the Committee on Human Services. Today I am also acting on behalf and speaking on behalf of the National Conference of State Legislators, so it is a dual role that I am here in.

I would first of all like to indicate to you, you look at the Medicaid changes and come up with some sort of a mixed blessing. Some of the things are clearly things that we think in California and the conference believes to be improvements. Obviously the issue of personal care which is one that is very near and dear to my heart is an issue that we have been involved in California to try to establish a nonmedical system. And as of today, we actually in the State legislature have passed legislation which will provide for the personal care option and we think that the administration was proposing to continue this personal care service is extremely important and we certainly want to bring it to your attention that it is more to maintain.

Also, the Ryan White AIDS Fund that you know is not specifically in here is very important to our State and will make a big difference in the future. Things that trouble you and trouble us are similar to what the Governors have indicated in their testimony. The issue of the enhanced administrative match is particularly troublesome for California because when we figure it out and we look at what we are actually going to be losing, we are losing in five program areas which are very important program areas, things like childrens' services, the comprehensive perinatal services, child health and disability prevention, case management, family planning, and drugs. These are important programs that without this enhancements would not have occurred to the extent that they have.

In addition to that, we also find that our claims system where we have automated with the incentive of the Federal Government and put forward to pay for 90 percent of the cost and subsidize 75 percent of the operating. So when we remove those enhancements what we find is that we lose $76 million from the State. Now, I have a chart——

Mr. TOWNS. How much, the numbers?

Mr. BATES. $76 million, and I would be happy to give you these figures and submit them for the record so that you could see how we actually parse that out. We were kind of taken back to find out that it was such a large amount. And of course I am sure that you are aware that these enhancements have actually enabled us to really make these programs work.

It is not just administration, it is providing the kind of outreach. It is being able to qualify people and make sure that people get proper screening and are administered in a way that allows them to get services in high-risk populations. So we think this is of significant importance to our State.

As the chairman of the committee I am sure is well aware and you may be aware, but California has been just in horrible, horrible shape. Our situation, we look at prospects of a $10 billion shortfall this year after having a situation with another $10 billion last year and $15 billion before that and $3 billion before that, so it is an incredible situation. So anytime we start moving around and making a cost shift, we feel it very directly and we end up having to do things that we really wouldn't like to do.

We are trying to figure out ways to make money go further. Cutting services, raising taxes in some instances, our current administration in Sacramento has indicated there are not going to be any new taxes whatsoever. We might be able to convince them that maybe some things are appropriate. So these cost shifts very directly hit the State.

In addition to that, the formularies, there has been an interesting discussion around the formularies and I enjoyed hearing it. We support what the administration is suggesting as well as the Governors and I see the red light is on and I appreciate the chance to be here and I would be happy to answer any questions.

Mr. TOWNS. Thank you very much, Mr. Bates.

[The prepared statement of Mr. Bates follows:]

STATEMENT OF
ASSEMBLYMAN TOM BATES
CALIFORNIA GENERAL ASSEMBLY

ON BEHALF OF THE
NATIONAL CONFERENCE OF STATE LEGISLATURES

Mr. Chairman and distinguished members of the subcommittee:

My name is Tom Bates. I am a member of the California General Assembly, where I chair the Human Services Committee. Today I am speaking on behalf of the National Conference of State Legislatures. NCSL represents the legislatures of the nation's 50 states, its commonwealths, territories and the District of Columbia.

My testimony is based on policies adopted by the NCSL's State-Federal Assembly, the policymaking body that guides our advocacy activities with Congress, the courts, and federal agencies. NCSL policies reflect our dedication to preserving a strong federal system of government, maintaining effective intergovernmental programs, protecting our nation's vulnerable populations, and developing creative, constructive domestic initiatives.

I am pleased to be here today to discuss President Clinton's Medicaid proposals. In general, these proposals are designed to increase program efficiency and to provide additional flexibility to states. The nation's legislative leaders, including myself personally, have conveyed to the President our bipartisan support for the objectives that would be achieved with passage of the overall economic recovery plan. It achieves essential deficit reduction - our most serious domestic challenge.

The economic recovery package generally protects state tax bases and to the extent we can determine, avoids exporting the federal deficit to the fiscally-troubled shoulders of state and local governments. The package also includes a much-needed short-term stimulus package that NCSL has fully supported. Finally, and most important to this subcommittee, the package makes a sizable and necessary long-term human capital investment that should be reassuring to our constituents as well as to those of us serving in public office.

The President proposes to: (1) continue as an option, personal care services; (2) repeal enhanced administrative matching funds for Medicaid, AFDC and Food Stamps; (3) permit states to establish and operate drug formularies; (4) tighten rules on the transfer of assets; (5) make permanent the limit on pension benefits to veterans in nursing homes; and (6) develop a health care program for refugees and undocumented residents. NCSL has carefully reviewed these proposals and would make the following recommendations.

Personal Care Mandate

NCSL is pleased that the Administration has proposed to continue, as an option, personal care services. I personally am very supportive of personal care services. Our experience in California has been a very positive one and we established personal care services as part of our Medicaid program recently. We believe it serves younger, disabled individuals particularly well, providing a real alternative to institutionalization. NCSL policy states that nursing home services provided through the Medicaid program should, "...recognize the important role non-medical personal care and social services play in maintaining a person's independence." I certainly agree and hope that our experience will encourage other states to adopt this cost effective and important program.

Repeal Enhanced Administrative Matching Funds

The Administration proposes to repeal existing enhanced administrative matching funds, matching all administrative functions at 50 percent. We oppose this proposal. Under current law, the following functions receive enhanced matching funds:

- 75 percent for compensation and training of professional medical personnel, and staff directly supporting such personnel, used in program administration;
- 90 percent for development and 75 percent for operation of automated claims processing systems;
- 75 percent for medical and utilization review or for quality review by an utilization and quality control peer review organization (PRO);
- 100 percent for implementing and operating an immigration status verification system;
- 90 percent for the first 3 years and 75 percent thereafter for establishing and operating a state Medicaid fraud control unit, subject to a limit of the higher of $125,000 or .025 percent of total federal and state expenditures in the state. currently available to encourage states to undertake certain types of administrative activities. All administrative functions would be matched at the 50 percent rate; and
- 75 percent for nursing home survey and certification activities.

In general, we believe that the reason certain administrative functions were provided additional federal funding was because of the overall importance of those functions to the Medicaid program. In the case of the immigration status verification system, states successfully lobbied for additional administrative support. The federal government agreed to pay the cost of the verification system, if states agreed to perform the verification. To repeal this provision would be reneging on a deal. Finally, it is important to note that recent regulatory actions and some of the proposals in this budget package will increase state administrative costs. Interim final rules implementing P.L. 102-234 are extremely burdensome. We hope the Administration will reconsider this proposal.

Permit States to Establish Medicaid Drug Formularies

The President proposes to restore to states the authority to establish drug formularies within the Medicaid program. As you know, states lost this authority with the enactment of the Medicaid drug rebate program in the Omnibus Budget Reconciliation Act of 1990. Under that program, prescription drug manufacturers are required to give state Medicaid programs the "best price" that they offer to other purchasers. In return, states are required to cover **all** drugs produced by participating manufacturers. The law permits states to establish "prior authorization" programs and establishes guidelines for the use of "prior authorization", but prohibits the use of Medicaid drug formularies.

NCSL supports the President's proposal to restore to states the authority to establish drug formularies. Many, if not most, health maintenance organizations (HMOs) and hospitals use drug formularies and/or prior authorization. States should be afforded the same choices and options that exist for other purchasers in the health care system.

Tighten Rules on Transfer of Assets

The Administration proposes to require states to establish estate recovery programs. The Administration also proposes to close loopholes in federal law to ensure that individuals with resources pay a fair share for nursing home care before the Medicaid program starts to pay. While we support the general thrust of this proposal, we would urge the Administration to move forward on closing the loopholes in federal law first, then allow states to experiment with various approaches to estate recovery. We believe a mandate in this area is premature. This is an area where the administrative burden could be substantial.

Third Party Liability

The Administration proposes to remove structural barriers to the proper identification and billing of liable third parties. The Administration proposes: (1) requiring employers to report employment-based health insurance data annually on W-2 forms; (2) granting access to this data to all federally-assisted and financed health programs; (3)) reinforcing existing coordination of benefits (which payor pays and in what order) laws and regulations; and (4) removing impediments that hinder states from collecting from private insurers. The proposal is designed to prevent the federal government from acting as the primary insurer when an individual has other coverage. We support this proposal.

Permanently Extend the Limit on Pension Benefits to Veterans in Nursing Homes

This proposal was a cost shift from the Veteran's Administration to the Medicaid program when it was enacted in 1990. The Administration is proposing to make it permanent. It continues to be a cost shift to states that we are less than enthusiastic about.

Health Care for Refugees and Undocumented Residents

The President proposes to design a program to offset the impact of refugees and undocumented residents on state and local governments. Although this proposal was not included in the Medicaid section of the President's proposal, coming from California, I would be remiss if I failed to mention my support of this proposal. NCSL looks forward to working with you and the Administration on this important issue.

Medicaid Provider Taxes

I would like to take a minute to say a few words about Medicaid provider taxes. As you know, interim final rules regarding the Medicaid provider tax law went into effect December 24, 1992. As you know, California uses intergovernmental transfers, which are still permitted and protected by the law. We urge you to continue to support the use of intergovernmental transfers.

States are finding it extremely difficult to craft programs that comply with all the rules set out in P.L. 102-234, the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991, and the accompanying rules. Mr. Chairman, NCSL thanks you for your leadership on this issue and we urge you to review this law and work with state legislatures to develop a law that would permit states to use this important revenue source, but would prevent abusive practices. The administrative burden and general uncertainty about what is allowable under P.L. 102-234 is untenable. Among the ideas gaining support among legislators is setting a limit on the amount of revenue that can be raised through provider taxes, but eliminating restrictions relating to the types of providers and the manner in which the revenue can be raised. We will be discussing this proposal with the Administration and hope to gain your support.

I thank you for this opportunity to share our thoughts with you today and would be happy to answer any questions you may have.

REDUCING ENHANCED ADMINISTRATIVE MATCHING FUNDS

IMPACT ON MEDI-CAL, LICENSING AND CERTIFICATION, AND CHILDREN'S MENTAL HEALTH

The overall loss to the Department of Health and Human Services for the federal proposal to cap matching expenditures at 50 percent is $76.2 million and is based upon current year costs.[1]

Local Assistance Loss	$ in Millions
Family Planning Drugs	$13.0
Case Management	8.0
California Children's Services	2.0
Comprehensive Perinatal	6.5
Child Health and Disability Prevention	3.7
Claims Processing/Fiscal Intermediary	29.3
Sub-Total, Local Assistance	62.5
Support	13.7
TOTAL	**76.2**

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[1] This is an adjustment from what was sent to the Health and Welfare Agency and does not include enhanced costs transferred to other agencies.

Mr. TOWNS. Ms. Krueger.

STATEMENT OF MARILYN A. KRUEGER

Ms. KRUEGER. Thank you, Mr. Chairman. I appreciate this opportunity to be able to testify. I am Marilyn Krueger and I chair the St. Louis County Board of Commissioners in Minnesota. I am also the Chair of the Health Steering Committee for the National Association of Counties.

I want to summarize my written remarks today because I would like a couple of minutes to make some personal observations.

Counties are critical to holding together today's tenuous health system. Counties care for persons with no health insurance. We see the uninsured and underinsured and Medicaid recipients. Our local health departments serve over 40 million persons a year. Millions are also served in our 581 county hospitals and we train approximately 26 percent of the physicians in this country in those hospitals.

Counties are on the front line in many facets of health care. Counties of the 1980's saw their general expenditures for health and hospitals increase by 105 percent after inflation. We are responding to these costs by raising in most cases property taxes and we are running into increased opposition from our constituents.

Overall, NACo views Medicaid cuts as shifting costs to States who often shift costs to county governments. During the 1980's, revenues from county sources increased 58 percent after inflation while sources from other governments increased by only 7 percent. We have become a Federal and State budget safety valve.

We oppose the reduction in enhanced Medicaid administrative costs. A reduction of 75 percent match of readmission screening programs and resident review for long term care would mean a cost shift to counties and/or a poorer screening process that would not identify the mentally ill or retarded.

On reimbursement of services for Medicaid in a reformed system, Federal reimbursement for services provided to the underinsured should be based on the service provided and not on the entity providing the service. Asset of transfer rules for Medicaid estate planning is a serious and growing problem and at home we call it welfare middle class.

In my county, we spend 6 percent of our financial assistance dollars on AFDC recipients and we spend 67 percent of our financial assistance dollars on the elderly. We pay 60 to 70 percent of the costs for people in the privately run nursing homes and we—though we have two nursing homes, we also subsidize those nursing homes. Our welfare retirees in northern Minnesota, known as snow birds, many of them leave the State when they retire. They do not pay income tax in the States where they take up residency and they return 20 years later after transferring their assets because we are a high service State.

It is my observation that I have constituents who are wealthy who are transferring their assets and now my middle-class constituents are catching on and they are doing the same thing.

I thank you for this opportunity to testify.

Mr. TOWNS. Thank you, Ms. Krueger.

[Testimony resumes on p. 533.]

[The prepared statement and attachment of Ms. Krueger follow:]

STATEMENT OF MARILYN A. KRUEGER, ON BEHALF OF NATIONAL ASSOCIATION OF COUNTIES

CHAIRMAN WAXMAN, MEMBERS OF THE SUBCOMMITTEE, I AM MARILYN KRUEGER, CHAIR OF THE ST. LOUIS COUNTY (MN) BOARD OF COMMISSIONERS AND CHAIR OF THE NACo HEALTH STEERING COMMITTEE. THANK YOU FOR THIS OPPORTUNITY TO TESTIFY.

COUNTIES ARE CRITICAL TO HOLDING TOGETHER TODAY'S TENUOUS HEALTH SYSTEM. COUNTIES CARE FOR PERSONS WHO HAVE NO HEALTH INSURANCE. WE SEE THE UNINSURED, THE UNDERINSURED AND MEDICAID RECIPIENTS. OUR LOCAL HEALTH DEPARTMENTS SERVE OVER 40 MILLION PERSONS A YEAR. MILLIONS ARE ALSO SERVED IN OUR 581 COUNTY HOSPITALS. AS PROVIDERS, PURCHASERS AND ADMINISTRATORS, COUNTIES ARE ON THE FRONT-LINE IN MANY FACETS OF HEALTH.

IN OVER TWENTY STATES, COUNTIES CONTRIBUTE TO THE MEDICAID ADMINISTRATIVE OR BENEFITS COSTS. ATTACHED TO MY TESTIMONY IS A LISTING OF THOSE STATES. THE FINANCIAL CONTRIBUTION DIFFERS AMONG STATES IN TERMS OF THE TYPES OF SERVICES THEY ARE REQUIRED MATCH AND THE PERCENTAGE MATCH. IN ADDITION TO THIS INVOLVEMENT, COUNTIES IN 36 STATES BEAR A LEGAL RESPONSIBILITY FOR THE MEDICALLY INDIGENT. IN 17 OF THOSE STATES, COUNTIES BEAR THE SOLE RESPONSIBILITY.

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* The National Association of Counties is the only national organization representing county government in the United States. Through its membership, urban, suburban and rural counties join together to build effective, responsive county government. The goals of the organization are to: improve county government; serve as the national spokesman for county government; serve as a liaison between the nation's counties and other levels of government; achieve public understanding of the role of counties in the federal system.

AS YOU KNOW, THE MEDICAID STATUTE GIVES STATES THE FLEXIBILITY TO RAISE FROM LOCAL GOVERNMENTS AND OTHER ENTITIES UP TO 60 PERCENT OF THE NON-FEDERAL SHARE OF MEDICAID. OVER THE LAST 15 YEARS, COUNTY GOVERNMENTS HAVE ASSUMED INCREASING PUBLIC SERVICE RESPONSIBILITIES DUE TO A DIMINISHED FEDERAL ROLE AND PRESSURES ON STATE BUDGETS. COUNTIES IN THE 1980'S SAW THEIR GENERAL EXPENDITURES FOR HEALTH AND HOSPITALS INCREASE BY 105 PERCENT AFTER INFLATION WHICH WAS ONLY SURPASSED BY TWO PERCENTAGE POINTS BY CORRECTIONS SPENDING. IN TERMS OF THEIR OVERALL ANNUAL BUDGET, SPENDING ON HEALTH AND HOSPITALS FOR THE AVERAGE COUNTY IS THE LARGEST LINE ITEM AT 17 PERCENT.

WE ARE RESPONDING TO THESE COSTS BY RAISING REVENUES. LAST YEAR, OVER 80 PERCENT OF URBAN COUNTIES TOOK THAT STEP AND THREE QUARTERS OF THEM EXPECT TO DO IT AGAIN THIS YEAR. A NACo SURVEY OF OUR RURAL COUNTIES SHOWED SIMILAR CHALLENGES AND RESPONSES.

BECAUSE OF OUR TRADITIONAL ROLE AS PROVIDERS TO THE INDIGENT, WE HAVE LONG SUPPORTED MEDICAID EXPANSIONS AND OPPOSED FEDERAL BUDGET CUTS IN THE PROGRAM. WHILE OUR COUNTIES WHO PARTICIPATE IN MEDICAID ARE EXPERIENCING ANNUAL DOUBLE DIGIT INCREASES IN MEDICAID COSTS, THERE IS RECOGNITION THAT WITHOUT THAT FUNDING, MORE COSTS WOULD BE PICKED UP BY COUNTY-ONLY PROGRAMS.

BEFORE I DESCRIBE OUR CONCERNS WITH THE PROPOSED MEDICAID CUTS, I WANTED TO DESCRIBE TO YOU RECENT STATISTICS OF LOS ANGELES COUNTY'S HEALTH SYSTEM. AS PROVIDER OF LAST RESORT, THE COUNTY OPERATES SIX PUBLIC HOSPITALS, SIX COMPREHENSIVE HEALTH CENTERS AND 40 PUBLIC HEALTH CENTERS. THEIR FACILITIES RECEIVE 173,000 ADMISSIONS, 516,000 EMERGENCY ROOM VISITS, AND 4.6 MILLION AMBULATORY CARE/PUBLIC HEALTH VISITS EACH YEAR. THEIR FOREIGN-BORN POPULATION COMPRISES SLIGHTLY OVER ONE-THIRD OF THE COUNTY'S POPULATION, YET THEY RELY HEAVILY ON THE COUNTY FOR HEALTH, REPRESENTING 58 PERCENT OF THE PATIENTS AND 61 PERCENT OF UNREIMBURSED COSTS. WHILE THEIR SIZE DWARFS OTHER COUNTIES, THEIR TRADITIONAL ROLE IS SIMILAR TO MANY COUNTIES IN MANY STATES.

OVERALL, NACo VIEWS MEDICAID CUTS AS SHIFTING COSTS TO STATES, WHO OFTEN THEN SHIFT COSTS TO COUNTY GOVERNMENTS. DURING THE 1980'S, REVENUE FROM COUNTY-OWN SOURCES INCREASED 58 PERCENT AFTER INFLATION, WHILE SOURCES FROM OTHER GOVERNMENTS INCREASED ONLY SEVEN PERCENT. WE HAVE BECOME A FEDERAL AND STATE BUDGET SAFETY VALVE. THIS IS PARTICULARLY TROUBLESOME IN HEALTH, BECAUSE OF THE ANNUAL DOUBLE-DIGIT INCREASES. MEDICAID CUTS INCREASE COSTS TO COUNTY INDIGENT CARE PROGRAMS.

I WILL NOW ADDRESS THE MEDICAID PROPOSALS. WHILE WE DO NOT HAVE OFFICIAL POLICY ON MANY OF THE PROPOSALS, WE DO OPPOSE THE REDUCTION IN ENHANCED MEDICAID ADMINISTRATIVE COSTS. A REDUCTION

OF THE 75 PERCENT MATCH FOR PREADMISSION SCREENING PROGRAMS AND RESIDENT REVIEW FOR LONG TERM CARE COULD MEAN A COST SHIFT TO COUNTIES AND/OR A POORER SCREENING PROCESS THAT WOULD NOT IDENTIFY THE MENTALLY ILL OR RETARDED. COUNTIES IN STATES SUCH AS PENNSYLVANIA, FLORIDA, NEVADA, AND NEW HAMPSHIRE COULD BE PARTICULARLY AFFECTED, ESPECIALLY NEW HAMPSHIRE, WHERE COUNTIES PAY 61.5 PERCENT OF THE NON-FEDERAL SHARE FOR LONG TERM CARE.

UNDER THE BUDGET PROPOSAL, THE ADMINISTRATIVE MATCH FOR THE INSTALLMENT AND OPERATION OF AUTOMATED DATA SYSTEMS WOULD ALSO BE REDUCED. THESE SYSTEMS ARE ESSENTIAL TO INCREASING EFFICIENCY AND IMPROVING SERVICE TO THE RECIPIENTS. IF THE FEDERAL GOVERNMENT IS SERIOUS ABOUT STREAMLINING PROGRAM ADMINISTRATION, THEN IT MUST CONTINUE ITS FINANCIAL COMMITMENT. FINALLY, FOR OUR COUNTIES WHO HAVE LARGE NUMBERS OF UNDOCUMENTED IMMIGRANTS, THE REDUCTION IN MATCHING FOR IMMIGRATION STATUS VERIFICATION SYSTEMS CONSTITUTES ANOTHER FINANCIAL BLOW. COUNTIES WOULD AGAIN BEAR ADDITIONAL COSTS, DUE TO THE FAILURE OF A NATIONAL IMMIGRATION POLICY.

ON TRANSFER OF ASSET RULES, NACo HAS NOT TAKEN A POSITION. HOWEVER, MANY LOCAL, STATE, AND FEDERAL POLICYMAKERS BELIEVE THAT MEDICAID ESTATE PLANNING IS A SERIOUS AND GROWING PROBLEM. WHILE THE DIRECT FINANCIAL COST IS DIFFICULT TO ASSESS, MANY ANECDOTES ABOUND ABOUT WELL-TO-DO NURSING HOME RESIDENTS RECEIVING MEDICAID BENEFITS WHILE KEEPING PERSONAL FORTUNES INTACT IN A SPOUSE'S, CHILD'S, OR CONSERVATOR'S CARE. ON THE OTHER HAND, ACCORDING

TO ADVOCATES FOR THE ELDERLY, THE DEARTH OF LONG TERM CARE INSURANCE LEAVES SENIOR CITIZENS WITH FEW OPTIONS.

SOME ARGUE THAT THE LOOSENESS OF THE SYSTEM IN ALLOWING PEOPLE TO RECEIVE PUBLIC LONG TERM CARE BENEFITS WITHOUT REALLY IMPOVERISHING THEMSELVES SIMPLY REFLECTS OUR TRUE SOCIETAL VALUES THAT PUBLIC LONG TERM CARE COVERAGE SHOULD NOT BE PROVIDED THROUGH A WELFARE MODEL. OTHERS ARGUE THAT IF WE TRULY FEEL THAT LONG TERM CARE SHOULD BE A MIDDLE CLASS BENEFIT, THEN WE SHOULD DEVELOP A FINANCING STRUCTURE TO SUPPORT SUCH A BENEFIT. WE SHOULD NOT DO IT THROUGH THE "BACK DOOR" APPROACH OF MEDICAID ESTATE PLANNING THAT CREATES INEQUITIES BY SHIFTING RESOURCES FROM PERSONS WHO ARE TRULY POOR AND WITHOUT HEALTH INSURANCE TO PERSONS WHO CAN WELL AFFORD TO PAY THEIR OWN WAY.

FINALLY, ON MEDICAID PERSONAL CARE SERVICES, NACo HAS NOT TAKEN A POSITION. AS A GENERAL POLICY, NACo OPPOSES FEDERAL MANDATES UNLESS THEY ARE FULLY FUNDED. WE SUPPORT STATE AND LOCAL FLEXIBILITY IN DELIVERING SERVICES. WHILE COVERING HOME HEALTH SERVICES FOR PERSONS ELIGIBLE FOR NURSING HOME CARE IS A LAUDABLE POLICY GOAL, THE STATE AND LOCAL FISCAL CONSTRAINTS ARE SUBSTANTIAL AT THIS TIME.

THANK YOU FOR GIVING ME THIS OPPORTUNITY TO TESTIFY. I WILL BE HAPPY TO ANSWER ANY QUESTIONS.

ATTACHMENT

ASSURANCE OF HEALTH SERVICES BY COUNTY GOVERNMENTS

INTRODUCTION

All levels of government shape and drive the ability of health systems to respond to the health care needs of their residents and jurisdictions. This paper will focus on the health service responsibilities of county governments, both as arms of the state and as independent local governments. Together with state governments and the Medicaid program, counties are major elements of the nations public sector health safety net.

WHAT ARE COUNTIES?

There are 3,044 county governments in the United States; they have functional responsibilities in all but two states[1]. Counties have two purposes. Originally created by the states as political subdivisions, counties have a significant role implementing state programs and policies.[2] Counties also are independent local governments responding to the particular needs of their residents; this role has grown considerably over the past two decades.

Several factors account for increased public responsibilities over the last 15 years, including the diminished federal domestic role, and changing social and economic realities that demand public attention. As states quickly experienced budget problems, increasing demands were placed on local governments.

Counties receive revenues according to their different roles: counties are authorized by the state to levy certain taxes to support services required by the state or demanded locally. States transfer funds directly to counties, and pass through substantial amounts of federal funds. There are minimal federal funds available directly to counties, except for grant and contract programs.

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[1] Counties are geographic jurisdictions but not functioning governmental entities in Rhode Island and Connecticut.

[2] Counties have broadest local governmental responsibilities outside the New England area; In Maine, Massachusetts, and Vermont, towns and townships are the basic unit of local government.

Although county tax structures have diversified, and the property tax share of local taxes overall has dropped from 88 percent in 1962 to 74 percent in 1985, property taxes continue to form the majority of county general revenues[3]. Taxpayer opposition is most often directed against locally imposed and controlled taxes; the majority of tax limitation initiatives have capped or controlled increases in property taxes. Sales taxes and income taxes raise more revenue than do property taxes, and are considered more progressive, but are not used much by counties. County governments are relying on fees and charges rather than taxes to pay for increasing numbers of services.

All local governments spend funds disproportionate to what they collect. Local governments are responsible for spending about one third of all general government revenues[4],while they are responsible for collecting about twenty percent. Counties comprise about four percent of the country's 83,000 local governments, and collect over 20 percent of general government revenues. Funds from the state and federal governments make up about 40 percent of the total revenues used by counties.

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[3] Ostrom, V. Bish, R. and Ostrom, E. Local Government in the United States. San Francisco: Institute for Contemporary Studies, 1988.

[4] Ibid.

HEALTH SERVICE RESPONSIBILITIES OF COUNTY GOVERNMENTS

Counties exercise broad community protection responsibilities both as arms of the state and as general purpose independent local governments. Both these roles have pulled counties into the mainstream of health service provision and assurance. The dual role of counties in this regard means they have a broader and more comprehensive role than any other local government entity.

County governments have a varying range of health service responsibilities. In nearly all states, they have some role related to public health services. In most, they are responsible, as government, for services the private sector declines to provide, usually to persons who have no financial resources. Many counties have specific legal responsibilities for indigent health care; while nearly all county officials have concerns for health issues as they relate to numerous social and economic problems in their community.

The organizational structure of county health services varies. In some cases, a broad umbrella agency oversees services ranging from traditional public health through primary and acute to long term care, including psychiatric, services for the developmentally disabled, and rehabilitation services. In other counties, each aspect of the health service system is housed in a different agency. In large urban areas, the umbrella agency approach is more prevalent.

Several general components are easily identified. The first is the public health department, the most basic and critical expression of government's concern for community well-being. Over three-quarters of the country's 2,932 local health departments serve county jurisdictions. The services under the purview of these agencies range from basic public health nursing to broad community and environmental protection and personal care services.[5] The involvement of county governments in local health departments varies. In most states, counties are directly responsible for the staff and organizational control of the health department. In some, notably in the south, separate districts have been set up to oversee the delivery of public health services. In these cases, the county role may be as a collector of the tax levy that supports the district, owner of the capital facilities in which programs operate or through appointment powers for the district board of directors.

Counties own and directly operate 581 hospitals across the country[6]. This activity is not necessarily related to other county responsibilities for health. For example, in Mississippi, the state staffs and controls the public health system at the local level, yet there are 49 county owned hospitals. The majority of county hospitals are small general acute care hospitals serving rural areas. Yet in urban areas, the public hospital is almost certainly a county hospital, and many premier medical training institutions rely on county hospitals. Nearly 26% of the nation's medical professionals have trained in a county owned hospital.

Under pressure from soaring medical costs, many counties have sought to divest themselves of hospital facilities, to move them to an arms length relationship by establishing independent authorities, or by hiring external management firms. A number of hospitals have spun off from county control to form quasi-independent corporations. In these cases, the county often continues to own the capital facility, contributes to the indigent care costs of the hospital, and/or has defined rights related to the governing board membership (either appointment or direct member status). Indigent care responsibilities of the county often remain independent of hospital ownership.

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[5] Details on the services provided by the nation's local public health departments are provided by the National Association of County Health Officials (NACHO), representing professional public health officers, and a NACo affiliate. See especially National Profile of Local Health Departments (NACHO, 1990) and Primary Care Assessment: Local Health Departments' Role in Service Delivery (NACHO, 1992).

[6] Information from the American Hospital Association, 1993.

Counties directly administer or provide funding for nearly two-thirds of the country's mental health clinics. In two states, Wisconsin and New Jersey, county involvement in mental health services includes psychiatric hospitals.

Counties are responsible for free standing long term care facilities, including bed and board facilities, skilled and intermediate care nursing homes, and residential facilities for the mentally retarded (ICF/MR). Counties operate significant numbers of these facilities in parts of New England and the midwest, especially New Hampshire, and Michigan, Ohio, Iowa, and Pennsylvania.

THE COUNTY ROLE IN RELATION TO MEDICAID AND THE INDIGENT

The county role in relation to Medicaid and the medically indigent parallels their role in health services generally and has two dimensions: implementing state mandates or programs, and in response to community needs as an independent local government.

States may require local governments to assist in matching up to 60 percent of the nonfederal share of Medicaid costs[1]. Twenty one[7] states require counties to participate in this way, an increase from 14 states in 1988. County assistance is based on a portion of costs for certain services, notably long term care or administrative activities, especially eligibility determination. Payments are based primarily on a percentage of total costs; as services have increased, so have county obligations in this regard. The use of local funds has gained increasing popularity since intergovernmental transfers have remained protected as a mechanism for matching federal funds. Several states have adopted statewide programs to pool county funds for this purpose or entered agreements with specific counties.[8]

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[7] Data from telephone survey conducted by National Association of Counties, 1992. See Appendix for specific contributions.

States that use local governments for Medicaid administration have higher costs, yet states have been reluctant to totally assume these responsibilities. Even though overall program costs would be reduced, savings would not accrue solely to states but be shared with the federal government.

Counties finance the non-federal share of the costs of administration for the Aid to Families with Dependent Children program in 18 states, as well as contribute to the benefit costs for AFDC in 11 states.

County governments bear responsibility as providers of last resort in 36 states. The level and actual assumption of this responsibilities varies. In 17 states, counties have the sole legal responsibility even in the presence of a state General Assistance program. In four states, the county is liable if they operate a hospital. In others, counties share this responsibility with the state or other levels of government. Ultimately, the ability of counties to respond to indigent needs depends on their fiscal ability to do so.

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[8] Although we know which states require county contributions, we do not have a clear understanding of county voluntary participation through administrative roles or the use of intergovernmental transfers.

Thirty nine states provide medical assistance benefits as part of a General Assistance (GA) program. In nineteen of these, county governments are responsible for funding and administering the GA program. Paid for entirely by state and local governments, benefits often vary between states and even within the same state; few states provide medical coverage similar to Medicaid for GA recipients.[9]

Counties provide funding for many community based organizations. Although not strictly "indigent care," this often overlooked activity contributes to the health and well being of the community and often delays or eliminates the development of more costly problems. In a recent survey, NACo found that nearly half of the funds provided by counties for acute care facilities went to proprietary and private non-profit hospitals. The same general proportions were reported for funding to mental health clinics, to long term care facilities, and to general health clinics. This finding shows the extensive nature of county support for community based health activities.

POLICY ISSUES RELATED TO HEALTH REFORM

There are several policy issues that emerge from a discussion of the role of county governments in local public sector health service systems. They relate broadly to financing, administration, and coordination of local health systems.

In general, public policy questions need to include a recognition of the differing revenue raising and spending capacities of the different levels of government. The broadest authority is at the federal level. States too, have fairly broad powers to raise and spend moneys, constrained by balanced budget requirements. Local governments are required to operate within balanced budgets, but may raise and spend revenues only as allowed by the state and as local constituencies will tolerate. Because of these realities, federal or state programs that require local cost sharing or matches should be carefully designed.

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[9] Nichols, M., Dunlap, J. and Barkan, S. National General Assistance Survey, 1992. Washington, D.C.; Center for Budget and Policy Priorities, 1992.

Although the ability to fund public services is most powerfully exercised at the federal level, the administration of service systems can be done by federal, state or local governments. Although costs are higher when local governments administer state programs, sensitivity to local needs can be assured by government's accountability through public elections. Requirements to assure uniform services and access must allow flexible approaches to meet local needs.

Uniform payment levels and rates, with minimum adjustments, would facilitate administration at all levels. Payment rates now vary for the same service from different facilities and providers, even between public and private providers. Since the volume and scope of Medicaid covered services has increased, competition has intensified; the ability of county facilities to become Medicaid eligible providers is critical. This is especially true given Medicaid's role as a major vehicle for the less traditional types of care such as nursing homes and home health care[10].

Local governments have no role in authorizing or licensing service providers. States have considerable authority and responsibility in this regard, but it is often disregarded or superseded by federal regulations.

Coordination of services is a significant issue, both from the perspective of service availability and system efficiency. A significant part of government's responsibility is for broad community protection through population-based public health services. As attention is focused on broadening services access for persons now at risk, a greater risk to our communities is being ignored. Clean water, immunization programs, health education, tracking and controlling disease are all essential if individual health is to be improved.

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[10] Advisory Commission on Intergovernmental Relations, Op Cit.

Concern for access reinforces continued use of state and federal categorical funding for community based providers, prompting a quasi-governmental system independent of existing local public programs. Costly duplication, system fragmentation, and inappropriate competition often result instead of coordinated and cooperative community systems.

CONCLUSION

In summary, attention to the "civics of health care" is essential to assure that local health service systems operate efficiently and effectively. State and federal governments should adopt programs and policies that include county governments and enhance the ability of local public service systems to work productively. Policy issues focus on the operation of local health systems, especially issues related to financing, administration and coordination.

1. Advisory Commission on Intergovernmental Relations. Medicaid: Intergovernmental Trends and Options. Washington, D.C., ACIR, 1992.

APPENDIX

REQUIRED PARTICIPATION BY COUNTIES IN STATE MEDICAID MATCH

ARIZONA

Under the Health Care Cost Containment System (a statewide Medicaid demonstration program), counties pay 100 percent of the non-federal shre on long term care for the elderly and physicially disabled, and fund a variable portion of acute care.

CALIFORNIA

Counties contribute 2.5. percent of administrative costs and paticipate in intergovernmental transfers.

COLORADO

Counties pay 40% of the non-federal share of administrative costs related to eligibility determination.

FLORIDA

Counties pay $55 per month for each nursing home resident, and 100 percent of the non-federal share for the 13th through 45th inpatient hospital days.

INDIANA

County tax levies provide approximately 50 percent of the non-federal share for Medicaid administrative costs at the county level. Counties contribute to a "Medical Assistance to Wards" fund used to pay the non-federal share of Medicaid for wards of the county office or juvenile court who are not eligible for AFDC foster care.

IOWA

Counties pay 100 percent of the non-federal share of ICF/MR; 100 percent of the non-federal share of MH/MR/DD waivers for home and community based services for persons normally served by ICF/MR; "enhancements" (i.e., Medicaid case management, partial hospitalization and day treatment for the chronically mentally ill, mentally retarded and developmentally disabled.)

MICHIGAN

Counties pay 10 percent of the non-federal share for Medicaid mental health services delivered by county community mental health agencies. Counties with medical care facilities (county nursing homes) provide a variable maintenance of effort payment for Medicaid patients in the facility.

MINNESOTA

Counties pay 100 percent of the non-federal share of administrative costs related to client services except for the child health plan, where the share varies. Counties loan funds to the state, without interest, for a portion of the state's benefit payments for the first six months of each fiscal year.

NEVADA

Counties pay 100 percent of the non-federal share of long term care for the aged, blind and disabled whose net monthly income exceeds $714 but is less than the maximum percent of the Supplemental Security Income Federal Benefit Rate (SSI/FBR).

Counties are required to pay the total administrative costs for the federal match program.

NEW HAMPSHIRE

Counties pay 100 percent of the non-federal share of the Medicaid Audit unit. Counties pay 61.5 percent of the non-federal share of long term care; and 50 percent of the non-federal share of all other services.

NEW JERSEY

Counties fund the non-federal share of administrative cost for eligibility determinations of non-SSI Medicaid applicants.

NEW MEXICO

As of April, 1993, counties will contribute about 7 percent of the total Medicaid budget through the use of intergovernmental transfers used by the state as Medicaid match.

NEW YORK

Counties pay 50 percent of the non-federal share of services, excluding long term care, for which they contribute 20 percent.

NORTH CAROLINA

Counties pay 15 percent of the non-federal share of services, and 100 percent of the administrative cost related to eligibility determination.

NORTH DAKOTA

Counties pay 13.1 percent of the non-federal share except for ICF/MR, clinic services, and waivered home and community based services for mentally retarded, aged and disabled residents. The average county share of all state and state/county matched Medicaid funds is 9.9 percent.

OHIO

Counties pay a maximum of 10 percent of the non-federal share of administrative costs related to eligibility determination, with some limitations.

PENNSYLVANIA

Counties pay 10 percent of the non-federal share for county nursing homes plus $3.00 per invoice.

SOUTH CAROLINA

Counties provide $13 million to support Medicaid through a formula prescribed by law.

SOUTH DAKOTA

Counties pay $60/month for each ICF/MR resident, and $200/month for each mentally ill resident in state inpatient facilities.

UTAH

Counties provide 20 percent of the state's non-federal payment.

VIRGINIA

Counties are responsible for part of the non-federal share of eligibility determination costs.

Mr. TOWNS. Let me just pause for a moment to indicate that we have been joined by Congressman Pallone from New Jersey who is a member of the committee as well.

So let me turn to you, Mr. Pallone, for any statements you may have or any questions at this time.

Mr. PALLONE. Thank you, Mr. Chairman. I came in late and I apologize for that. I really don't have any questions. I realize the importance of this issue, though, not only in terms of the current budget, but also in terms of what we might do for health care reform.

Without prejudice to anything that has already been said today, I was very pleased to read in newspaper accounts in the last few weeks that Medicaid might be folded into the health care reform because I think that is important, but I am just here to listen. Thank you.

Mr. TOWNS. On that note, then that is a real concern of a lot of people that that might be used for roads and bridges and everything else, but what is supposed to be used for so I think that is another concern. Mr. Bates, you mentioned enhancement.

Mr. BATES. Enhanced match.

Mr. TOWNS. Could you sort of elaborate on that a little further?

Mr. BATES. Sure, I would be happy to. What happened is the Federal Government in order to encourage the States to start the various programs or to expand various programs said to them that they would give a match that would be more than 50-50. They would provide in some cases as much as 90 percent if you would make certain changes and actually augment your programs.

So a perfect example of that would be the claims where we in California and other States have a lot of difficulty in terms of our state of technology, so the Federal Government said "Well, we will help you to modernize and put in computers and make these changes and specifically we want you to do this because we are going to pay 90 percent of the cost for you to make those changes and not only will we make the 90 percent cost to help you make the changes, we will also underwrite your operating costs by giving you instead of 50-50, a 75-25 match." So that is an example.

Now what is being proposed is to go back to 50-50 so we are no longer getting the 75-25. It drops back to a 50-50 match so it basically puts you out on a limb. You really don't have any choice but to either cut out the service or raise taxes or do something else so it is a direct transfer of the costs to the States.

Mr. TOWNS. Thank you. Let me sort of look at it in terms of the various loopholes. You have had long years of experience in terms of looking at this whole problem. What are some of the loopholes that you feel should be closed, either one of you, specific loopholes?

Mr. BATES. Well, are you talking about in the health field now?

Mr. TOWNS. In the whole process, some of the loopholes in terms of Congress, things that we should now be involved in.

Mr. BATES. I think that speaking of myself now, I think that the most important thing is for you to establish and the administration to come up with a national health policy and service that will in fact take in the Medicaid people so that we don't have this bifurcated system, two and three different types of medical care systems and to the extent that the poor get treated like everyone else and in terms of type of systems, service they get, the type of drugs and the type of other things, mainstreaming them would be the best thing that you could do to close the loophole because now we try to figure out ways to get around and not serve, changing hospitals, closing hospitals, basically putting a lot of roadblocks in the way of people getting services because we want to keep the costs down.

So if we had a system that was truly a system where everybody was included and the costs were spread, it would be a fairer system and a much better system in my opinion.

Mr. TOWNS. Yes, Ms. Krueger?

Ms. KRUEGER. Mr. Chairman, I think the asset track issue is something that definitely needs to be looked at.

Mr. TOWNS. Mr. Volpe?

Mr. VOLPE. Mr. Chairman, I agree with both of my fellow panelists here. Both asset transfer needs to be looked at, but I also agree very much with Mr. Bates and the Governors would, too, that we need to reexamine the entire structure for providing health care for low income individuals. The Medicaid program is being stretched and pulled and its funding and financing structure is becoming somewhat tenuous clearly for States and I suspect on some level for Congress as well.

So we need to really reconsider as part of a national health reform a permanent way of providing health care to low income individuals and also at the same time make sure we avoid this notion of a two-tiered health system so that low-income individuals have the access to quality health care that every other American has.

Mr. TOWNS. Thank you. One problem that we are having here is that the providers in many instances will not admit that there is a two-tiered system. We had people to testify here today who indicated that does not exist and, well, I just think that is a real problem because many of us know that it exists, but when you have providers not admitting it, you know, it makes it hard sometimes to do anything about it.

It is just like a situation where you have a school and the principal will say there are no problems in the school because he feels that if he admits that there are problems, then it is a bad school, rather than to say that there are problems and open up and be able to get some help.

I think that this is what we are having here with providers that many of them are just not being honest about this whole process and it is creating a real problem in terms of how we get to it and begin to really change it and to make it work and work effectively.

Ms. KRUEGER. Mr. Chairman, we know that there is a two-tiered system whether or not they want to admit it because our county health departments and our county hospitals clearly indicate that we are taking people who otherwise are not receiving any kind of health care.

Mr. TOWNS. Well, let me just thank you very, very much for your testimony and for your insight into this problem. I know you agree with me that it is a very complicated one and one that over the next few months that I think we will all be devoting a tremendous amount of time to it and thank you again for your suggestions and recommendations.

Thank you very much. This concludes the hearing. Thank you.

[Whereupon, at 2:45 p.m., the subcommittee was adjourned.]

[The following letter and statements were submitted:]

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March 31, 1993

The Honorable Henry Waxman
Chairman, Health and Environmental Subcommittee
Energy and Commerce Committee
2408 Rayburn Building
Washington, D.C. 20515

Dear Mr. Chairman:

This letter is written to express my concern regarding the proposal to repeal the federal prohibition of prescription drug formularies. There are a number of potential consequences I would ask you to consider.

Various studies, including those of Harvard and Vanderbilt, have shown that drug formularies do not save money and may actually increase total health care costs. It is estimated that 30 million patients will be served by Medicaid programs. Formularies would restrict their drug access and coverage.

Most important is the value of individualized drug therapy. All drugs of a certain type are not completely alike. Each drug in a therapeutic class differs from other drugs within that class. Differences in drug composition and interaction of prescription drugs should be taken into account with individual patients.

The Louisiana legislature repealed its Medicaid formulary after finding that such a policy restricted access and caused health and economic damage. Additionally, many believe that restrictive formularies deny Medicaid patients access to the best drugs available, creating a system of second-class care for needy citizens.

I appreciate your consideration of these facts as you and your committee consider changes in prescription drug policy for our country.

Sincerely,

Wm. J. Jefferson

PRINTED ON RECYCLED PAPER

STATEMENT

of the

AMERICAN ASSOCIATION OF RETIRED PERSONS

This testimony examines two widely discussed long-term care financing issues: (1) estate planning and transfer of assets by potential long-term care consumers; and, (2) the initiatives by some states to establish "Long-Term Care Public-Private Partnerships."

In general, AARP is concerned about proposed efforts to further "tighten" rules governing estate planning and the transfer of assets in the absence of a comprehensive long-term care program which addresses the needs of people of all ages and incomes. Without such a program, middle income families would continue to be vulnerable because they would not readily qualify for Medicaid; could not afford to pay for care out-of-pocket; could not afford meaningful private insurance protection; and would not have the resources necessary to prepare for their financial future. Thus, in the absence of a comprehensive social insurance program, average Americans needing long-term care would continue to face the likelihood of having their life savings wiped out.

This testimony will also discuss the risks and adverse implications of the partnership programs for federal and state health policy in general as well as for consumers who might participate in these programs. These programs link the purchase of a private long-term care insurance policy with a waiver of all or part of Medicaid's asset test for determining eligibility.

ESTATE RECOVERY AND TRANSFER OF ASSETS

A popular but uninformed perception is that large numbers of wealthy older people are sheltering their assets to obtain eligibility for nursing home coverage. This perception, based on anecdote only, has led to consideration of proposals that would make the Medicaid eligibility determination process even more onerous.

Although AARP has always discouraged abuse of the Medicaid eligibility process by those that the program was never intended to protect, many of the methods being discussed would make the process even more complex and difficult for Medicaid nursing home applicants, the vast majority of whom are poor, old and frail. Onerous means-testing requirements would become more, rather than less, stringent. Some steps could be taken, however, which might allow states to curtail abuses by closing certain Medicaid loopholes. In the effort to close loopholes, however, we cannot condone a system that makes a complex, intrusive process even worse for the typical Medicaid applicant. Further, we strongly believe that any resulting savings should be used to help pay for improvements in our nation's long-term care system.

Evidence of a Problem -- The perception that such sheltering is widespread warrants a more objective examination than has heretofore been undertaken. We are anxious, for example, to receive a forthcoming General Accounting Office report on the subject, which we understand will include some original research and should be available in some form this Spring. Raymond Hanley and Joshua Wiener of the Brookings Institution have also made the following important points:

- The vast majority of nursing home residents are poor widows with little or no incentive to manipulate the system. Eighty-six percent of the disabled population aged 75 and older has less than $15,000 in annual income and 57 percent of this same population has less than $10,000 in financial assets. Thus, not much wealth is available for transfer to heirs or others. Some poor, older people with disabilities have homes but, given that the home is an exempt asset under Medicaid, sheltering of this particular asset should not be considered an abuse of the system.

- If sheltering assets is an increasing problem among the older population, then the number of Medicaid recipients in nursing homes should be rising dramatically. The data, however, show that the number of Medicaid nursing home recipients increased less than 2 percent a year between 1985 and 1990. This rate is consistent with the growth in the overall nursing home population. In addition, the aged accounted for only 4 percent of Medicaid enrollment growth between 1988 and 1991 -- only 200,000 out of 4.8 million new Medicaid recipients.

Other analysis of the prevalence and impact of Medicaid transfers relies on interviews, in a handful of states, with government officials, nursing home administrators, and others who describe their perceptions of the problem. In addition, the rate of growth in advertisements for estate planning and in the number of lawyers specializing in this field is often cited as proof of increased manipulation of the Medicaid program. There is no hard evidence regarding the scope of the problem in specific states or around the country.

Another question to consider is why older people would seek so assiduously the dubious benefit of Medicaid eligibility. Being on a welfare program like Medicaid generally is not considered to be desirable. The following disadvantages lead one to ask why anyone would want to manipulate their finances to get onto Medicaid when there is little that is attractive about being a recipient. They face:

o An often humiliating, stigmatizing impoverishment process that forces them to deplete their financial resources and to lose their financial independence;

o Discrimination by nursing homes against Medicaid recipients. Nursing homes in all but two states receive lower payments for Medicaid recipients than they do for private-pay residents. Such discrimination can take the form of:

(1) a separate Medicaid wing, some with four residents per room, with a generally poorer environment than in the private pay wing; (2) poorer quality of care; and (3) fewer activities and poorer food and quality of life in general.

- A $30 per month personal needs allowance in most states that is not indexed for inflation and generally is insufficient to provide for necessities that Medicaid's payment does not cover.

The above concerns lead us to question the assumptions that have been used to estimate budget savings from "tightening" such practices and whether these savings are realistic. What, for example, are the assumptions regarding the degree to which these practices are occurring? Have potentially high state administrative costs been factored in? Has the degree to which truly wealthy individuals, who can afford to hire increasingly sophisticated attorneys, will alter their behavior to take advantage of any new or remaining loopholes been considered?

Options for Closing Loopholes -- Anecdotes about sheltering practices has led policymakers to consider methods for tightening transfer of asset provisions and mandating estate recovery programs. Some proposals may be less harmful to Medicaid applicants than others. Examples of areas that could be looked at include: (1) treatment of certain types of Medicaid qualifying trusts; (2) treatment of multiple transfers; (3) placing reasonable limits on the amount of protected funds that can be placed in an irrevocable funeral contract; and (4) clarifying interstate enforcement of Medicaid eligibility rules when assets are held in one state and a person is in a nursing home in another state.

In addition, states should consider efforts such as: improving data collection systems; appointing conservators to protect incapacitated recipients from expropriation of property by relatives or others; enforcing current transfer restrictions through strong property ownership identification techniques; and partitioning of undivided property.

Making the overall Medicaid process even more difficult and intrusive than it already is, however, would have a deleterious effect on the typical applicant for Medicaid's nursing home coverage. For instance, increasing the "look-back" period from 30 to 60 months would impose an enormous paperwork and administrative burden on the typical very frail, poor nursing home resident and would generate little savings. An applicant either would have needed the foresight to keep detailed records of all her financial transactions for the five years preceding her application for Medicaid, or she would have to have a way of proving that all of her financial dealings were not for the express purpose of gaining Medicaid eligibility. If the applicant made some improvements to her home or gave some money to a grandchild to help with college expenses, would she be denied Medicaid eligibility? Would she be forced to undergo an intrusive, humiliating inquiry during which she would have the burden of proving that she was not engaged in fraud?

Another set of options would affect a Medicaid applicant's home. One option would condition Medicaid eligibility upon acceptance of a lien on one's assets, including the home. Another option would limit the amount of the exemption for a person's home. Under such proposals, applicants would have to give up a home if its value were too high or agree to lose it upon entering a nursing home in order to gain coverage. These restrictions might make it financially appealing for relatives of a person needing nursing home care to discourage that person from seeking it.

The key to reforming the Medicaid eligibility process is to analyze how the process and any proposed changes would affect the typical applicant. Currently, applicants face uninformed caseworkers; myriad state eligibility requirements; long, complicated application forms; and changing federal and state rules. In about 19 states without medically needy programs, nursing home residents cannot spend-down their incomes to qualify for Medicaid coverage. Even if the cost of nursing home care exceeds their incomes and they have impoverished themselves, they cannot get coverage.

Policy makers should also consider that restricting sheltering practices would disproportionately impact elderly widows, simply by virtue of the fact that they make up the vast majority of nursing home residents. In addition, the inconsistency between the financial eligibility requirements for Medicaid coverage of acute versus chronic conditions would be exacerbated.

AARP advocates a thorough examination of the Medicaid eligibility process to institute well-considered reforms that improve the process for those truly in need and that close loopholes used by few wealthy applicants who are trying to manipulate the system. In addition, any Medicaid savings that accrue to the federal government resulting from reform of the Medicaid eligibility process should be used to improve our nation's long-term care system.

Finally, it is important to keep in mind that most of those making the allegation that these sheltering practices are widespread have an agenda of their own. Nursing home representatives, for example, generally want to be able to admit private pay residents rather than Medicaid eligible residents to receive higher payment rates. Many making these allegations also are trying to sell more private long-term care insurance policies. Such policies, however, cannot provide the answer to our nation's long-term care crisis.

PRIVATE LONG-TERM CARE INSURANCE

To a family for whom a $30,000 hospital bill is not different from a $30,000 nursing home expense, further limits on estate planning and the transfer of assets in the absence of comprehensive long-term care reform will only further confuse their attempts to plan for long-term care expenses. Current private long-term care insurance policies provide little help. Their shortcomings include:

- Private long-term care insurance policies all rely on medical underwriting to control risk. As a result, these policies are only sold to healthy people, excluding those with pre-existing medical conditions and often those over 85 years of age.

- Most policies have restrictions which limit their coverage adequacy. These include lack of inflation and nonforfeiture protection, unstable premium rates, poor coverage of home care, and restrictive benefit triggers.

- Those policies that do provide meaningful protection are very expensive. A policy purchased at age 65 that will provide worthwhile protection over time will cost approximately $2,500 per year and up. In an analysis conducted in 1991 by the Brookings Institution, only 20% of the elderly population could afford private long-term care insurance by the year 2020, assuming they could afford a policy for 5 percent of their income and have at least $10,000 in nonhousing assets.

- Private insurance is not a "good buy" relative to social insurance coverage such as Medicare. Insurance companies have administrative and marketing costs such as advertising, agent commissions and company profits which Medicare does not have. As a result, the consumer will pay much more for these costs when compared to the 2-3 percent administrative costs in Medicare.

New long-term care insurance policies referred to as "Long-Term Care Public-Private Partnerships" have only recently come onto the market in several states. These policies are now available in Connecticut and New York and will soon also be available in Indiana and California. The partnership programs link the purchase of such a policy to a Medicaid asset test disregard. Their purpose is to make it easier for certain consumers to qualify for Medicaid by allowing them to circumvent Medicaid asset divestment requirements if they have purchased a qualifying long-term care insurance policy. These policies, which may at first seem attractive but are quite complex, suffer from serious shortcomings. For example, according to a report the U.S. General Accounting Office (GAO): "The Medicaid program could experience cost increases, while consumers risk not receiving the benefits they expected." ["Long-Term Care Insurance: Proposals to Link Private Insurance and Medicaid Need Close Scrutiny," September 1990, HRD-90-55]

LONG-TERM CARE PUBLIC-PRIVATE PARTNERSHIPS

Under the Partnership programs, individuals are encouraged to purchase private long-term care insurance policies at their own expense. The consumer must then meet certain criteria before he/she can take advantage of the asset disregards. In Connecticut, Indiana and California, the standard Medicaid asset limit would be waived on a dollar-for-dollar basis for long-term care services that are (1) paid for under the private long-term care insurance policy and (2) covered under the state's Medicaid program. The partnership, however, does nothing to make it easier to meet the state's income test for Medicaid eligibility. In New York there is no dollar-for-dollar match; rather, all assets are protected once a three-year nursing home benefit, or equivalent six-year home health benefit, is used up.

The proposals would allow persons of greater financial means to purchase long-term care insurance to avoid the normal asset "spend-down" requirement that accompanies Medicaid eligibility. This would, in effect, make it relatively easier for them to qualify for Medicaid program benefits than for persons of more modest means -- most of whom cannot afford a private long-term care insurance policy, but who may also experience great difficulty meeting the program's stringent resource requirements. In most states, single persons with assets exceeding only $2,500 do not qualify for Medicaid.

Adverse Implications for Federal and State Health Policy -- AARP is concerned that the effect of the partnership programs will not be positive -- either for Medicaid or for consumers. Linking the purchase of private long-term care insurance with Medicaid eligibility likely would result in: **(1) long run cost increases which could reduce services to other Medicaid recipients; (2) inappropriate institutionalization, and; (3) little or no useful data for at least another 20 years.**

Medicaid Cost Increases -- The cost implications for Medicaid resulting from these proposals continues to be speculative and controversial. We really will not know for about 20 years whether and how much the partnership programs will increase Medicaid spending. Analysis conducted by Lewin/ICF for AARP has indicated that Medicaid expenditures could be expected to increase over the long run under the partnership programs. The GAO testified that the programs might cause Medicaid expenditures to increase and issued a report stating that not all relevant factors were considered by participating states in calculating the cost of the program and "... a thorough analysis of the projects' cost estimates appears warranted." We strongly agree.

The market for private long-term care insurance generally is limited to healthy older persons with higher than average incomes and levels of education. In our view it is reasonable to assume that most of those purchasing partnership policies are the same persons who would have otherwise purchased a standard long-term care insurance policy in the absence of a partnership product. Moreover, it is unlikely that an asset protection feature alone will attract a substantial numbers of purchasers who would not otherwise buy a policy. For example, a recent study by Lifeplans, Inc. entitled "Who Buys Long-Term Care Insurance?" found that only 14 percent of respondents listed asset protection as the "most important" reason for buying long-term care insurance. If purchasers of partnership policies are able to more easily become Medicaid eligible relative to purchasers of standard policies (which generally cover a much longer period of time in the nursing home and still require persons to spend-down all their assets to become Medicaid eligible), then making partnership policies available will contribute to Medicaid expenditures increasing beyond what they would otherwise be. The GAO report also points out that "If...higher income individuals predominate among the participants, they could add to Medicaid rolls and hence to overall Medicaid costs." Not surprisingly, concerns are raised when the report later states that New York "estimates that 73 percent of its project participants will be higher income persons..." The report, therefore, recommends that Partnership programs be required to "limit the amount of assets that individuals can protect from Medicaid's spend-down requirements. This would lessen the risks of subsidizing persons who have other resources and thereby increase Medicaid costs."

Particularly in New York, where it is theoretically possible for millionaires who have long nursing home stays to be on Medicaid for many years, spending significant amounts of precious public dollars on such individuals under a program designed as a safety net for the poor, seems unfair as well as unwise. The GAO report has also stated that, in contrast to the other states' programs, "New York's proposed project poses relatively more risk of Medicaid cost increases..."

Given increasing state and federal concerns about runaway Medicaid expenditures, we believe it was extremely risky for DHHS to have approved and Congress to have permitted such proposals absent a much more thorough, public discussion of the programs' cost assumptions and implications. In our view, these decisions should be reconsidered and any further approvals should be put off until such an analysis can be conducted.

There are many good reasons to increase Medicaid spending, but we do not believe this to be one. Such increased costs could jeopardize access to health services for the poor at a time when state and federal resources for the program are very limited.

Inappropriate Institutionalization--Both the Medicaid program and private long-term care insurance policies are well known for their institutional bias and lack of adequate home care coverage. Since a participant's assets would be protected only for payments made for services covered by both Medicaid and the private insurance policy (except in New York), the program creates a strong incentive to choose institutional care over any other option. Although the participating states currently have somewhat better than average Medicaid home care programs, severe cutbacks in these programs are being seriously considered in some of the states because of budget problems.

Little or No Useful Information Generated -- Since most purchasers of long-term care insurance do not go into claim status until they are over 80 years of age, information derived from this proposal will have little value for at least another 20 years. It is our understanding, for example, that the average purchase age for these policies in Connecticut is 58. Since the participating states' Medicaid programs are much different from those of most other states, findings made pursuant to the partnership programs will be of little or no use elsewhere. Further, we are concerned that some states have claimed that these programs are demonstration projects, with the potential of affecting national policy. Given the extended period before which any reliable information will be available, justifying such proposals as demonstrations is disingenuous at best. They constitute important, disturbing changes in Medicaid policy which are moving forward without adequate debate having taken place.

Adverse Implications for Consumer Participants -- Even if the public policy concerns could be resolved, the lack of essential consumer protections make the program a dangerous risk for any participant. Under these proposals, older Americans who enroll and spend large sums of money in premiums expecting that certain protection would be received run a substantial risk of never actually getting this protection. Several specific concerns arise here: **(1) there is a likelihood that purchasers will never meet Medicaid's income eligibility requirements; (2) the consumer protection standards for certified long-term care insurance policies are inadequate; (3) there is no guarantee that current Medicaid long-term care benefits will be covered when they are needed; and (4) the asset protection features are not portable.**

Inability to Meet Income Requirements -- The partnership programs affect asset but not income requirements for Medicaid. As a result, individuals who would never qualify for Medicaid because their incomes were too high could purchase insurance based on the mistaken assumption that their ability to get Medicaid coverage would be virtually assured simply because some or all of their assets had been disregarded. Medicaid's income requirements are very strict, particularly in the 19 states without medically needy programs. In states with medically needy programs, there could be an inflationary incentive to go into the most expensive nursing homes so that enough income could be spent down to meet Medicaid's income eligibility criteria. In general, however, for many of the potential purchasers who would have the most to gain under the asset disregard in this proposal the income generated from protected assets could keep them from ever gaining eligibility.

The only way to bring even minimal fairness into this process would be to mandate that clear and concise information regarding Medicaid income requirements (including examples of how assets may generate income) be presented in a uniform format to each potential purchaser. In addition, information on where to get help should be readily available along with an approved self-assessment form (so that the individual can make a determination of the likelihood of ever qualifying) and a signed acknowledgement by the individual that he/she has received the materials and understands the risk of not qualifying.

Inadequate Policy Certification Standards--The long-term care insurance market, as reports from GAO and Office of the Inspector General have indicated, suffers from many serious shortcomings in the area of consumer protection. As a consequence, AARP must question any endorsement of a program built almost entirely around such private insurance policies when agent behavior is of great concern, pricing assumptions are questionable, real protection is lacking in many policies and comparison among products is so difficult for consumers.

Inadequate standards for certification of insurance policies are of particular concern, as they further increase the likelihood that consumers will be misled into purchasing illusory protection. Without additional information on final state regulations it is difficult to state with certainty which standards remain problematic. Our preliminary analysis of several state proposals, however, indicate that several areas are of major concern, including:

o **Standards on Mandatory Nonforfeiture Protection** -- Many policyholders cannot afford to pay the premiums over a long period of time, especially if premiums increase. Therefore, many policies are dropped or "lapse" with the policyholder having grossly overpaid for the protection actually received, with no permanent remaining insurance coverage. According to the GAO: "On average, insurers we reviewed expected that 60 percent or more of their original policyholders would allow their policies to lapse within 10 years."

  Reasons for lapsing include increases in long-term care insurance policy premiums, death of a spouse or some other financial problem. In some cases, Medigap insurance policy premium increases can cause a policy holder to drop their long-term care insurance policy. Despite the fact that the NAIC recently recommended that states mandate that all policies include nonforfeiture protection, states have not yet developed such standards.

- **Standards on Rate Stabilization** -- Unlike typical medical insurance policies, almost all long-term care insurance policies pay a fixed indemnity amount; therefore, premium increases cannot be justified by increases in health care costs. Unfortunately, insurers have largely avoided risks by transferring them to policyholders in terms of unpredictable premium rates. If companies incur more claims than expected or if lapse rates are lower than predicted, premiums will be increased. States have generally done little or nothing to ensure that premiums remain stable.

- **Standards on Benefit Triggers** -- Instead of using benefit triggers appropriate for long-term care (e.g. ADLs), many companies use medically-oriented triggers (i.e. medical necessity) which will not cover someone if they need custodial or personal care. States need to be sure that standards prohibit the use of triggers that will unduly restrict the availability of benefits.

In summary, there are substantial consumer protections that would have to be incorporated in order to provide meaningful protections to policyholders.

Absence of Benefit Guarantees -- The partnership proposals generally contain no guarantees that the protection and Medicaid-covered services currently in place in states will still be available when policyholders begin filing claims 10 to 20 years from now. A typical 65-year old purchasing a policy under the program probably will not need long-term care for another 15 to 20 years. Given the very serious current budget problems in many states, and the strong possibility that Medicaid services could be cut in the future, this is a particularly grave concern. Nor do there seem to be any assurances that states entering into such arrangements today would be bound to honor their commitment 10 to 20 years from now.

Are individuals to be given assurance that even if the state drops this program in the future that they will be "grandfathered" under the terms at the time they took out the long-term care insurance policy? "Truth in advertising" should be a foremost concern so that potential purchasers receive what they have been promised and what they believe they are paying for. A statutory or regulatory change would be necessary to ensure coverage at the level promised.

- Lack of Portability -- Partnership policies only provide a Medicaid disregard if a policyholder receives services in the state in which the policy is purchased. Thus, the asset protection feature is not portable should a policyholder move to another state. Marketing materials we have seen have not sufficiently disclosed this limitation to prospective purchasers.

CONCLUSION

With regard to placing further restrictions on asset transfers and other estate planning activities, AARP cautions that it is very risky to change national policy on the basis of anecdotes. We have particular concerns about unintended consequences for middle and lower income persons. A thorough evaluation of the problem, as well as of the Medicaid eligibility process in general, should be conducted before moving forward aggressively in this area.

While the Association supports the development and use of meaningful long-term care insurance products, neither private insurance nor the partnership proposals will be able to protect the vast majority of Americans from the extraordinary costs of long-term care. Each has major drawbacks which limit their effectiveness in adequately addressing the problem. We urge that the DHHS reconsider and that Congress review whether states should be permitted to use asset disregards in this way, particularly given the fact that the partnership programs permit and even encourage limited Medicaid dollars to be spent on wealthy, even rich, individuals that the program was never intended to serve.

Independently, restricting shelters and making partnership policies available to wealthy persons both have the potential for adversely affecting middle and lower income Americans. Taken together, these activities have even more serious implications for these vulnerable populations. Such trends are also indicative of the fragmented, schizophrenic non-system our nation now has to address long-term care problems. Our overriding conclusion in looking at these disturbing trends is that they illustrate the clear need for a comprehensive, universal solution to the problem based on social insurance principles. Until we begin to move in that direction, average middle class American families will continue to suffer from an unfair and disproportionate burden when a family member becomes chronically ill or disabled.

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Statement
# of the
American Hospital Association
before the
Subcommittee on Health and the Environment
# of the
Committee on Energy and Commerce
# of the
United States House of Representatives
on
The President's FY 1994 Budget

March 31, 1993

SUMMARY

- The American Hospital Association (AHA) is very concerned about the impact--on hospitals and their communities--of the Medicare and Medicaid savings proposed in President Clinton's Fiscal Year (FY) 1994 budget.
- Reductions to the direct medical education payments, continued reductions in payment for outpatient services as well as restructuring payment for radiology, anesthesiology and pathology will exacerbate an already difficult situation for many financially troubled hospitals.
- Moreover, hospitals have contributed to deficit reduction in every recent budget reconciliation package.
- And controlling future Medicaid program spending must be evaluated in broader terms than the dollar amount of budget savings to ensure that Medicaid beneficiaries have access to quality care.
- It is imperative that whatever budget savings are ultimately enacted, they be linked to the long-term goal of a health care reform package that provides both universal access and a restructured delivery system.
- Until this systemic reform becomes a reality, we must continue to seek fairness in the current Medicare and Medicaid programs.

Mr. Chairman, I am Rick Pollack, Executive Vice-President for Federal Relations at AHA. I am accompanied by Jim Bentley, Senior Vice-President for Policy. On behalf of AHA's 5,300 institutional members, I am pleased to testify today on the Medicare Part B and Medicaid provisions in the President's FY 1994 budget proposal.

I would like to cover two basic points in my testimony this morning. First, the AHA is very concerned about the impact further Medicare and Medicaid savings will have on the nation's hospitals and the communities they serve. Second, although some short-term budget savings may be necessary, it is imperative that they be linked to the long-term goal of a health care reform package that provides both universal access and a restructuring of the delivery system.

As you know, the Administration's FY 1994 budget proposals for Medicare and Medicaid are one part of an economic package that aims to stimulate the economy, create long-term job growth and reduce the federal budget deficit. We support these goals and believe it is in the best interests of the communities we serve that the nation's economy gets back on track. We further recognize that a strong economy generates job growth and health coverage in the private sector. To achieve deficit reduction and economic growth, the President has asked for sacrifices to be made. We understand that hospitals need to participate in the shared sacrifice required of all Americans in the short term to attain our shared long-term goals.

Yet, as we work toward these laudable goals, we must ensure that the sacrifice is fair and that budget decisions lead toward, not away from, a solution to our nation's health care crisis. To accomplish real and fair health care reform, everyone needs to understand how budget decisions made today will affect hospitals and their communities.

In May, when the President presents his comprehensive health care reform plan to the Congress and the American public, we will all be engaged in an important discussion about the future of our nation's health care system. While we look forward to that dialogue and are eager to work with this subcommittee and the Congress, we must ensure that existing federal programs do not undermine providers' ability to meet the legitimate needs of their patients. Purely budget-driven decisions can exacerbate our nation's health care problems and weaken the infrastructure upon which a reformed system must be built. Consequently, we need to carefully examine President Clinton's FY 1994 budget proposal in terms of its impact on hospitals and the communities they serve.

MEDICARE AND MEDICAID SAVINGS IMPACT

The President's budget proposal calls for nearly $60 billion in savings for Medicare and Medicaid over the next five years. This comes at a time when AHA estimates that for FY 1993 two-thirds of the nation's hospitals were forced to subsidize the cost of treating Medicare patients while four-fifths subsidized the cost of treating Medicaid patients in FY 1991. Many of these vulnerable hospitals provide the only access to health care services for specific populations such as the poor, elderly and rural Americans. Reductions in Medicare and Medicaid spending have exacerbated shortfalls between payments and costs in ways that hospitals cannot sustain. AHA has specific concerns about the President's budget proposals.

OUTPATIENT PAYMENTS

The proposals offered by the Administration serve only to further fragment outpatient payment policies without taking any steps toward comprehensive reform. Continued tinkering with the numerous payment systems currently used to pay for outpatient services meets short-term budget needs only. While we look forward to examining the Administration's proposal for reform of outpatient payment, we believe that only with systemic reform will these issues be adequately resolved.

GRADUATE MEDICAL EDUCATION

The President's budget proposes significant cuts in payments to hospitals that train physicians. The budget recommends basing direct medical education payments on a national per resident amount--using resident salaries only--and further modifying payments by differential weighting depending on choice of specialty. We understand the need to implement incentives to train more primary care physicians, but do not believe that paying hospitals less for training other physicians is the incentive that will most affect the choices of graduating medical students. Only long-term, comprehensive reform of the delivery and financing of health care will properly align incentives in the direction of primary care.

Cuts in graduate medical education could exacerbate the financial situation of teaching hospitals--many in our nation's inner cities--where residents in training provide a large portion of the care to the medically indigent.

PAYMENT FOR INPATIENT RADIOLOGY, ANESTHESIA AND PATHOLOGY

AHA is encouraged by the Administration's apparent commitment to aligning hospital and physician incentives as a method of controlling spending across all sites of care. In fact, a bundled payment is consistent with our vision of reform and the need for integrated payments. However, until these incentives are broad-based and the delivery system is restructured at the local level by collaborative arrangements among hospitals and physicians, hospitals should not be unfairly burdened by a federal requirement imposing a new relationship on hospitals and their medical staffs.

HOSPITAL-BASED HOME HEALTH SERVICES

The President's budget proposes to reduce payments for services provided by hospital-based home health agencies. These reductions could result in access limitations for some beneficiaries. A 1992 General Accounting Office report indicated that add-on payments for hospital-based home health agencies (HHAs) are consistent with Medicare reimbursement principles, recognizing that mandatory Medicare cost-reporting procedures result in approximately 13 percent more overhead costs attributed to hospital-based programs. In commenting on this report, the Department of Health and Human Services also pointed out that "hospital-based HHAs can offer more services to the beneficiaries and offer a continuum of care not available from freestanding HHAs . . . where hospital-based [HHA] are adversely affected by eliminating the add-on, beneficiary access to certain quality services may be reduced." It logically follows that eliminating payment adjustments that reimburse hospitals for legitimate cost differences and promote access to services are not in the best interest of the communities we serve.

MEDICAID ADMINISTRATIVE MATCH

The President's budget proposal calls for approximately $8.7 billion savings in Medicaid program changes over the next five years. AHA asks that the options for controlling future Medicaid program spending be evaluated in broader terms than simply the dollar amount of budget savings. The Medicaid program serves as the insurer of last resort for the most vulnerable of all Americans--it is the safety net for the poor and medically indigent. Reductions in a program already underfunded to the point that it can only pay 82 cents for each dollar of acute care it purchases must be carefully planned so we do not deny access to quality health care to those most in need of public support.

A significant portion of the Medicaid savings called for in the President's budget proposals will be realized through decreases in the federal portion of the administrative expense of operating the Medicaid program at the state level. This comes at a time when states are facing severe fiscal pressures. A closer look at the many different administrative functions performed at the state level shows that program administration focuses on much more than eligibility processing and claims payment. Certain administrative functions are critical to protecting the financial integrity of the program; examples include anti-fraud and abuse units, audit programs, and coordination of payment with other insurers. Limiting these activities may result in higher program costs in the long run if the states are less able to ensure the fiscal integrity of their programs.

There are other costs of reducing administrative expenditures that cannot be measured solely on a dollar basis. These are the human costs of limiting programs designed to assure that Medicaid recipients have access to high quality services. Utilization review is one type of program designed to safeguard the quality of care; facility certification/licensure is another.

AHA'S VISION FOR HEALTH CARE REFORM

The proposed Medicare Part B and Medicaid savings in the President's plan total over $24.7 billion for FYs 1994-1998. They must be viewed, however, in a broader context. Hospitals have made significant contributions to deficit reduction in past budget bills; Medicare hospital savings in the Omnibus Budget Reconciliation Act of 1990, for example, totaled almost $16 billion. And any reductions in the Medicaid program must also be subject to the keenest scrutiny to evaluate both their dollar savings and their human costs because adversely affecting the health of the elderly, poor, and indigent mothers and children is too high a price to pay for short-term stimulus of the economy.

Despite the magnitude of these savings, this year presents us with an opportunity we have not had in past years. It is imperative that whatever budget savings are ultimately enacted in the short term are accomplished fairly and that we remain focused on the long-term goal of meaningful reform that achieves universal access and a restructured health care delivery system.

Further, we must ensure that these measures do not freeze the current fragmented health care system in place. The solution to our nation's health care crisis is not in tinkering with current flawed payment systems such as Medicare PPS. Indeed, meaningful health reform can only come about through universal access and restructuring both the financing and delivery system to encourage more prudent and appropriate behavior by providers, payers, and consumers at the local level. Only in this way will we achieve universal access to needed services at a cost this country can afford.

The AHA's top priorities are achieving universal access and restructuring health care delivery around Community Care Networks.℠ These networks would be consortia of hospitals and other institutional providers, physicians and other health care professionals, insurers, employers, unions and others groups.

Networks would be expected to provide patients with a broad, coordinated continuum of care, focused on improving the health status of their enrollees. In return, community care networks would be paid on a capitated basis, receiving a fixed annual payment per individual. The allocation of resources among providers within the network, including the method and level of payment to various participating providers, would be determined within each network.

Networks would give providers greater freedom to make decisions without micro-management by government payers and insurers. In exchange, networks must be accountable. Networks might provide regular reports to communities on health status improvement, patient satisfaction, and provider satisfaction with network relationships.

The AHA believes that community care networks hold the best promise for reducing inappropriate competition within our system; improving patient care; and eliminating unnecessary care, duplication of services and excess capacity. Restructuring our health care system into capitated networks will increase the focus on preventive and primary care services.

CONCLUSION

As America's hospitals prepare for health care reform they must continue to operate under the current system, complete with a flawed and inequitable Medicare program and a Medicaid program that struggles to serve as the current safety net for the medically indigent. We stand ready to work with you to achieve these goals as well as to make the difficult choices required to meet the President's goal of a stronger economy. The President has asked for shared sacrifice from all Americans, including the nation's hospitals--many of which are financially vulnerable because of continued tinkering and past deficit reduction efforts.

We have worked with our members to develop a constructive approach to respond to the nation's health care crisis and look forward to working with you and the Administration in the months ahead. AHA is committed to meaningful health care reform that achieves universal access and a restructured health care delivery system.

℠ - CCN, Inc. and San Diego Community Healthcare Alliance use the name Community Care Network as their service mark and reserve all rights.

TESTIMONY OF
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PRESIDENT AND CEO
NATIONAL COALITION OF HISPANIC HEALTH AND HUMAN SERVICES ORGANIZATIONS (COSSMHO)

Members of the Subcommittee, I am pleased to have this opportunity to provide the perspective of the National Coalition of Hispanic Health and Human Services Organizations (COSSMHO) on President Clinton's economic plan, "A Vision of Change for America," proposal to repeal the Omnibus Budget Reconciliation Act of 1990 (OBRA '90) provision that forbids States from operating restrictive Medicaid drug formularies. However, before providing our perspective on this issue I would like to provide you with some background on COSSMHO.

COSSMHO is the only national organization with a primary mission of improving the health and well-being of Hispanic communities. We represent the needs and concerns of over 350 community-based organizations and 1,000 professionals providing health and human services in Hispanic communities. All COSSMHO programs utilize a community-based empowerment model of service delivery as evidenced by the fact that 60% of the COSSMHO budget funds community-based programs. COSSMHO also operates a computer bulletin board network of 350 Hispanic community-based organizations organized in 35 regional health coalitions. Given our community-based health mission, COSSMHO does not accept funding from tobacco or alcohol companies or their subsidiaries, the only national Hispanic organization to have adopted this organizational policy. Founded in 1973, COSSMHO is celebrating its 20th anniversary as the nation's action forum for Hispanic health.

As the nation's leading organization for Hispanic health care consumers, COSSMHO is deeply concerned by the misguided perception that restrictive Medicaid drug formularies will result in cost savings without a significant impact on the quality of patient care. President Clinton's economic plan calls for the "repeal [of] the OBRA 1990 statutory provisions that prohibit States from using formularies . . . States could cover only the generic alternative of a multiple-source drug . . . Estimated savings: over four years--$70 million; 1997--$25 million." COSSMHO has several basic concerns with this proposal.

Cost Savings Unlikely: There is no evidence that restrictive drug formularies have ever saved any money; if anything, there is evidence that restrictive drug formularies cost money in terms of treatment costs resulting from the cheapest rather than the most appropriate pharmaceutical being prescribed for patients. Studies from Vanderbilt University and Louisiana State University (LSU) have shown that Medicaid drug formularies do not save money and may actually increase total health care costs. The Vanderbilt study reviewed data from 47 states spanning the period 1985-1988 and found that restrictive formularies increased expenditures on Medicaid by at least 4.1 percent. These results were echoed in the LSU study which found that restrictive formularies do not result in cost savings on a total costs or on a per capita basis.

The most recent example of the effect of prescription by cost instead of by patient need is the case of Secretary of Defense Les Aspin. Military doctors gave Secretary Aspin a typhoid shot known to cause nausea and fever, aggravating a congenital heart condition, instead of a more expensive oral vaccine with few side effects. The cost to the Pentagon of a typhoid vaccine injection is 35 cents compared to the $1.90 cost of the oral vaccine. The result of the cheaper vaccine being administered was that Secretary Aspin was hospitalized with breathing problems which resulted mainly from the typhoid inoculation that induced a fever and aggravated his heart problem. According to a spokesman to the Secretary, the "injection vaccine was used because it's cheaper than the oral one." Of course, the $1.55 cost savings was lost in the first minute of Secretary Aspin's hospital stay.

Generic Drugs Not Always Equal Substitute: It is incorrect to assume that generic drugs are equivalent substitutes for name-brand pharmaceuticals. Issues such as differential absorption patterns and side effects need to be considered in prescribing the most effective treatment for a patient. Use of a generic substitute for certain patients may have the effect of increased side effects and additional treatment costs due to those side effects. Differences in the chemical composition and interaction of prescription drugs must be taken into account with individual patients. Generic substitution on a cost rather than treatment effectiveness basis is inappropriate in a quality health care system. The lowest priced drug may or may not be the best available therapy for an individual patient.

Quality of Care Compromised by Drug Formularies: The decision about the most appropriate treatment for a patient should always be a decision made by the health provider, the patient and their family--not a policy analyst in the State Medicaid office. The quality of patient care is seriously compromised when health care providers cannot prescribe the most effective drug for the specific needs of individual patients because certain pharmaceuticals may be on a restricted list. Drug formularies disempower the consumer by taking away their authority and role in health care decision making.

Drug Treatment Outcomes Differ for Racial and Ethnic Groups: Drug formularies that set up lists of approved and restricted drugs based on national or state data will not appropriately consider the differential impact of specific pharmaceuticals on different racial and ethnic groups. For instance, research has shown that antidepressants (imipramine, desipramine, amitriptyline and clomipramine) have greater side effects when prescribed for Hispanic populations than for non-Hispanic white population and care needs to be taken to prescribe antidepressants that have the fewest side effects (please see attachment: Ethnic and Racial Differences in Response to Central Nervous System Agents). When restrictive drug formularies do not give appropriate weight to the differential impact of certain pharmaceuticals on racial and ethnic groups, then the quality of care for those communities is seriously compromised.

Proposed Restrictions Affect Low-Income Only: As currently proposed, restrictive drug formularies would affect Medicaid recipients only. There are serious equity concerns in targeting restrictions in pharmaceutical access only to low-income consumers. Such a proposal expands the already significant gap in health care access and quality of services between high income and low income populations.

In addition to being opposed to restrictive drug formularies for the reasons of cost, quality and equity outlined above COSSMHO is also concerned with the practice of "prior authorization" under State Medicaid programs which has the same practical effect of restrictive drug formularies. This concern was expressed by former Secretary of Health and Human Services, Louis Sullivan, M.D., when he wrote to the 50 governors, "I am concerned by reports and speculations that the drug rebate legislation might be implemented in a way that could inappropriately restrict access to prescription drugs. In particular, it is speculated that 'prior authorizing' of drug dispensing, while permitted by the statute might be misused unfairly to deny access to medically necessary drugs for Medicaid beneficiaries. I do not believe it was the Congress's intent that this should happen." In fact, violation of Congressional intent has been occuring through the misuse of prior authorization. By requiring a physician to obtain permission, or "prior authorization," from a State employee before certain prescriptions can be filled and reimbursed by Medicaid, State Medicaid programs discourage prescribing of certain pharmaceuticals because of the burdensome approval procedures.

Prior authorization programs adopted by a number of States with significant Hispanic populations--including California and Florida--deprive low-income Hispanic communities of medications their physicians conclude are most appropriate. Such Medicaid access restriction policies divert tax dollars intended for patient care into the support of a new expensive and unnecessary administrative bureaucracy that discourages patient access without generating real budgetary or expanded access benefits.

COSSMHO calls on the Members of the Subcommittee to (1) reject the proposal to repeal the OBRA '90 provision that forbids States from operating restrictive Medicaid prescription drug formularies and (2) act in 1993 to tighten the existing prior authorization loophole that allows States to curtail Medicaid patient access to appropriate pharmaceutical treatment. Thank you for the opportunity to provide COSSMHO's perspective on this important health care access and quality issue.

ATTACHMENT: **Ethnic and Racial Differences in Response to Central Nervous System Agents**

Comparison Groups	Drug Class	Clinical Response
Chinese/Whites	Benzodiazepines (diazepam, alprazolam)	Chinese require lower doses; more sensitive to sedative effects
Chinese/Whites Hispanics/Anglos	Antidepressants (imipramine, desipramine amitiptyline, clomipramine)	Chinese and Hispanics require lower doses; side effects greater in Hispanics
Asians/Whites	Neuroleptics	Asians require lower doses
Asian Indians/Whites	Analgesics	Asian Indians have greater clearance rates
Chinese/Whites	Analgesics	Chinese less sensitive to cardiovascular and respiratory effects, but more sensitive to GI side effects

Sources: (1) Kalow W. Ethnic differences in drug metabolism. Clin Pharmockinet 1982;7:374-400; (2) Wood AJJ, Zhou HH. Ethnic differences in drug disposition and responsiveness. Clin Pharmokinet 1991;20:350-73; (3) Lin K-M, Poland RE, Lesser IM. Ethnicity and psychopharmacology. Cultur Med Psychiatr 1986;10:151-65.

Statement of
Martha Keys
Vice President
Public Affairs

of the

National Multiple Sclerosis Society

Mr. Chairman and members of the Health and Environment Subcommittee, my name is Martha Keys. I am the Vice President for Public Affairs of the National Multiple Sclerosis Society, and I wish to submit the following comments for the record on behalf of the National Multiple Sclerosis Society and its 400,000 members. It is our concern that your evaluation of the proposal to repeal the Omnibus Budget Reconciliation Act of 1990 provision which prohibited states from operating restrictive Medicaid prescription drug formularies does not result in re-creating this option as a cost-savings method at the expense of necessary and quality health care.

Multiple sclerosis is a chronic, often disabling disease of the central nervous system, the brain and spinal cord, that effects more than a third of a million people in the prime of their lives. It is most commonly diagnosed between the ages of 20 and 40, and it is the second most common non-traumatic neurological disorder among young adults. Women are more than twice as likely than men to have MS. This disease costs the society more than $2.5 billion annually. MS is often characterized by periods when symptoms intensify (relapses) or improve (remissions), or by steady progression of symptoms. These symptoms may include mobility impairment, overwhelming fatigue, sensory changes, loss of coordination, visual disturbance, and bowel and bladder dysfunction. The cause is unknown and no specific treatment for the underlying disease has been identified.

Multiple sclerosis (MS) serves as a paradigm for chronic, disabling conditions. While primary symptoms are neurologically based, multiple systems may be affected including urinary, respiratory and gastro-intestinal. Symptoms vary widely among individuals and also fluctuate over time in each person. Onset is generally during young adulthood, but with a near-normal life expectancy, thirty to forty years of disease duration can be anticipated. During this time symptom relief and prevention of complications can have a profound impact upon quality of life and reduction of costly episodes of increased morbidity.

Medical management of patients with MS involves continuous manipulations of therapies to achieve optimal benefit and to accommodate the fluctuations in disease manifestations. Various drugs within a particular group may be prescribed sequentially until the desired effect is achieved. Following are some examples of drugs within groups "anticipated to have the same effect", but not interchangeable in management of MS dysfunction.

1. Lioresal vs. Dantrium. Both drugs reduce spasticity of spinal origin. However, Lioresal has been demonstrated effective at high doses without serious side effects (main side effect is drowsiness), while Dantrium has been shown to result in liver toxicity in many cases.

2. Tricyclic anti-depressants. While all drugs in this group are anti-depressants, individual medications are used for their ancillary effects in managing several MS problems.

- Tofranil is used for its anti-cholinergic action to manage storage and combined neurogenic bladder dysfunction.
- Desyrel might be selected as the anti-depressant of choice for individuals with emptying dysfunction.
- Elavil is very effective in relieving specific kinds of pain associated with MS.

3. Anticholinergics. Storage and combined types of neurogenic bladder dysfunction are treated with drugs in this group, including Probanthine and Ditropan. Tofranil is also used for its anti-cholinergic side effects for these bladder problems. There is usually a "trial-and-error" process with a particular drug or combination of drugs, and titrating of dosage based upon response. There is considerable variance in individual response to these drugs, and each one must be titrated to establish the most effective regimen.

4. Dilantin vs. Tegretol. Although these drugs are both anti-convulsants, Tegretol is the therapy of choice for MS root pain, while Dilantin does not have this same benefit.

As you can see from the examples above, drug formularies that do not provide physicians with flexibility in treatment would absolutely result in eliminating necessary health care options and symptom management for people with MS. The net result would be lower quality health care.

The National Multiple Sclerosis Society urges you not to institute Medicaid prescription drug formularies.

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March 31, 1993

Testimony for the Health and Environment Subcommittee

There is little need to address the reason we are here. Health care reform is an issue that helped elect this administration. Cost containment is a goal that must be obtained before health care costs destroy American competitiveness and wreck the budgets of many states. The Texas Legislature, in which I serve, has, for example, raised taxes and cut a number of programs in order to afford to fund the Medicaid programs which we are partners in with the federal government.

Those of you who are more recent alumni of state legislatures remember the Medicaid cost spiral that you faced and that we still face. Congress has also taken many steps over the past decade to slow the increase in health costs, including prospective reimbursement to hospitals, support for health maintainence organizations and caps on physician's fees. Each of these measures and countless other steps are trade offs among cost, access and quality. The outcome we are all seeking is cost effectiveness. Not paying the most for the best, not paying the least for the cheapest, but paying a fair and reasonable price for services that actually improve the health status of our constiuents.

Drug formularies, lists of drugs that are available to a patient, are a part of the business of pharmacists. They are a basic process we learn about early in our professional education. The beauty of drug formularies is their simplicity - - they are simple to understand and simple to use. They standardize the pratice of pharmacy like a recipie standardizes cooking. Would that peoples' medical problems, or people themselves, were like widgets - - interchangable, replaceable and standardized.

As a pharmacist I assure you that this is absolutely not the case! Health professionals of all types will tell you that individuals react differently to the same therapy. This is particulary true of individuals who's physical process is already compromised by disease.

The same drug can have different effects on the same person at different times. Even different generic drugs, that is, drugs which have the same active ingredients, vary in effect on the same patient because of variances in manufacturing processes and inactive ingredients. And drugs of different but similar chemical make up, the type of drug used in so-called theraputic interchange, can act in markedly different ways with sublte --but substantially different-- results in patients. The stated goal of allowing states to establish formularies is to allow them to reduce their Medicaid costs by choosing one or a limited numbers of drugs available for a particular medical condition and buying of that drug. Your hope, I presume, is that volume purchasing and competition among the already very competitive pharmaceutical companies will result in a lower price. While this works in the controlled environment and limited populations that comprise hospitals and health maintainence organizations, it can not be expected to work well in the uncontrolled and large population of an entire state, especially a state like Texas where almost half of the state is of minority status.

Emphasis on formularies to restrain the increase in Medicaid costs to the states misses the point in my experience. For some reason, the percieved high cost of drug therapy is seen as an enormous expense outside the other components of the health care system. This is not true. The widespread use and popularity of drug therapy --the whole basis on which my profession is built --rests on cost-effectiveness, the goal which we are all striving for. As you know drug therapy accounts for less than seven percent of health care costs. This seven percent figure fallen from 13% in the 1960s. Even if the cost of drugs were completely eliminated from the health care cost equation, there would only be a brief decline in the increase in health care costs. The entire savings to any health care budget would be eaten up within a matter of months, not years.

A factor that is often overlooked is the cost savings that drug therapy provides by eliminating the need for more expensive and intensive care --additional physician visits, hospitalization and nursing home visits-- not to mention the mitigation of suffering and the occurance of premature death. Proper drug therapy delays the disability caused by any number of conditions: heart disease, arthritis and AIDS to name only three. Proper drug therapy prevents the complications of conditions such as diabetes where victims can loose their legs, their sight, their means of livelihood. While some of the costs of a lack of proper drug therapy can be calculated in dollars, many can not.

But, what is proper drug therapy, besides being cost effective? The answer to that question is as individual as the patients and their diagnoses. To help make this determinitation, OBRA '90 mandated, along with relatively open drug formularies, monitoring the way drugs are used, so called "drug utilization review" or DUR. This review is to be applied both prospectively and retrospectively to assure the right drug is prescribed in the right amount for the right period of time. In Texas, this concept was applied to the newer ulcer medications even before the OBRA '90 mandate. The results have been outstanding. Instead of denying patients drugs that help them feel better and avoid costly surgery,or allowing patients an unlimited supply of expensive product, physicians and pharmacists are reminded of generally accepted doses and periods of therapy. Eceptions are readily made to accomodate the range of Medicaid patient conditions. This simple program has paid for itself many times over without sacrificing the cost effectiveness of treatment or the quality of care.

Thinking of this innovative approach reminds me to invite the members of this committee to look at the Medicaid vendor drug in my state. The program's mission is to provide necessary drug therapy as a cost effective alternative to other services, not to see how small and limited and restricitve a Medicaid drug program the state can get away with.

Remember again that people's reactions to drug therapy vary widely. Dealing with these variances in a cost effective manner is not possible with a limited formulary outside of a controlled environment. Limiting physicians' options will not attract them to take care of Medicaid patients. Cost effectiveness is more than the matter of how much a drug costs, it is a matter of how much the drug can achieve combined with its costs.

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